

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 35854
Registrar's No. 210

BIRTH NO. _____ REG. DIST. NO. 324 PRIMARY REG. DIST. NO. 3082

972

WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH a. COUNTY <u>Saline</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY <u>Saline</u>	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Marshall</u>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Marshall</u>	
c. LENGTH OF STAY (If in hospital or institution) <u>Lifetime</u>		d. STREET ADDRESS (If rural, give location) <u>507 E. Jackson</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION. <u>507 E. Jackson</u>			

3. NAME OF DECEASED (Type or Print)	a. (First) <u>Annie</u>	b. (Middle)	c. (Last) <u>Richardson</u>	4. DATE OF DEATH (Month) (Day) (Year) <u>Oct. 21st, 50</u>
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5. SEX <u>Female</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Widow</u>	8. DATE OF BIRTH <u>Dec. 15- 1868</u>	9. AGE (In years last birthday) <u>81</u>	# UNDER 1 YEAR Months <u>10</u>	# UNDER 1 YEAR Days <u>6</u>	# UNDER 1 YEAR Hours <u></u>	# UNDER 1 YEAR Min. <u></u>
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Hair Dresser</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>at home</u>	11. BIRTHPLACE (State or foreign country) <u>Arrow Rock, Mo.</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
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13a. FATHER'S NAME <u>Unknown</u>	13b. MOTHER'S MAIDEN NAME <u>Unknown</u>	14. NAME OF HUSBAND OR WIFE <u></u>
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, or unknown) (If yes, give war or dates of service) <u>No</u>	16. SOCIAL SECURITY NO. <u>NO</u>	17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>Mrs. Laura Mason, Kansas City, Missouri</u>
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18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Coronary Occlusion</u>		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Hypertension</u> DUE TO (c) <u>Senility</u>		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		<u>1201</u>	

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?
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22. I hereby certify that I attended the deceased from medical investigation, to 10-24, 1950 that I last saw the deceased alive on 10-24, 1950, and that death occurred at 10:30 a. m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) <u>C. L. Lawrence, M.D.</u>	23b. ADDRESS <u>Marshall, Mo.</u>	23c. DATE SIGNED <u>10-24-50</u>
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24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	24b. DATE <u>10/29th/50</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Fairview Cemetery, Marshall, Mo</u>	24d. LOCATION (City, town, or county) (State)
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DATE REC'D BY LOCAL REG. <u>Oct-27-1950</u>	REGISTRAR'S SIGNATURE <u>Sidney F. Gray</u>	385	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>John Green & Sons, Marshall, Mo</u>
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RECEIVED 11-1-50
DISTRICT HEALTH OFFICE No. 3
District File Number _____
Date Filed 11-1-50

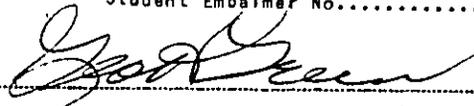
STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by _____

working under my personal supervision.

Student Embalmer No. _____

Signed _____



Signed _____
Student Embalmer

Licensed Embalmer No. 4520

P. O. Address _____

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.