

FILED JUN 23 1951

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. 21409

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1009 Registrar's No. 5266

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE MISSOURI b. COUNTY	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis, Missouri	c. LENGTH OF STAY (In this place)	c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis 2099	
d. FULL NAME OF HOSPITAL OR INSTITUTION St. Louis City Hospital #1		9. STREET ADDRESS (If rural, give location) 4518 N. 19th St	

3. NAME OF DECEASED (Type or Print)	a. (First) JOSEPH	b. (Middle) J.	c. (Last) RICHMOND	4. DATE OF DEATH (Month) (Day) (Year) JUNE 7 1951
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5. SEX M. 0	6. COLOR OR RACE W	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) MARRIED 1	8. DATE OF BIRTH Sept 13, 1885	9. AGE (In years last birthday) 65	IF UNDER 1 YEAR Months 8 Days 24	IF UNDER 24 HRS. Hours Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) COSTODIAN	10b. KIND OF BUSINESS OR INDUSTRY RANKINSCHOOL	11. BIRTHPLACE (State or foreign country) St. Louis MO	12. CITIZEN OF WHAT COUNTRY? USA.
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13a. FATHER'S NAME William Richmond	13b. MOTHER'S MAIDEN NAME UNKNOWN EHLE	14. NAME OF HUSBAND OR WIFE SARAH RICHMOND
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No	16. SOCIAL SECURITY NO. 493-09-4991	17. INFORMANT'S SIGNATURE OR NAME ADDRESS SARAH RICHMOND 4518 N. 19th St.
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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, asthenia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH (Specify)
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Pulmonary Tuberculosis - Far advanced		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Perforated Ileum			

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input 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? PO2X
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22. I hereby certify that I attended the deceased from 6-4-51, 19\_\_, to 6-7-51, 19\_\_, that I last saw the deceased alive on 6-7-51, 19\_\_, and that death occurred at 11:55A m., from the causes and on the date stated above.

22a. SIGNATURE James H. Hutchinson, M.D.	(Degree or title)	23b. ADDRESS 1515 Lafayette Avenue	23c. DATE SIGNED 6-7-51
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24a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL 11	24b. DATE 6/11/51	24c. NAME OF CEMETERY OR CREMATORY CALVARY	24d. LOCATION (City, town, or county) (State) St. Louis MO
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DATE REC'D BY LOCAL REG. JUN 8 1951	REGISTRAR'S SIGNATURE J. B. Lassater	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Stout - Carroll 4600 Hall Bldg
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WRITE PLAINLY—USING BLACK INK—MAKE A PERMANENT RECORD

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 \_\_\_\_\_

Student Embalmer No. \_\_\_\_\_

working under my personal supervision.

Student .....  
Student Embalmer

Signed

*Bent Hoffmann*

Licensed Embalmer No.

*4366*

P. O. Address

*St Louis Mo*

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

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