

FILED FEB 5 1952

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 1718

495

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

BIRTH NO. _____ REG. DIST. NO. 156 PRIMARY REG. DIST. NO. 200L Registrar's No. 42

| | | | |
|--|--|--|--|
| 1. PLACE OF DEATH a. COUNTY JASPER | | 2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE MISSOURI b. COUNTY JASPER | |
| b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Joplin | | c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN DUENEWEG 0490 | |
| c. LENGTH OF STAY (In this place) 30 MIN | | d. STREET ADDRESS (If next, give location) 616 PATTERSON | |
| d. FULL NAME OF HOSPITAL OR INSTITUTION St. Johns Hospital | | | |

| | | | | | |
|---|--|--|---|--|--|
| 3. NAME OF DECEASED (First) (Middle) (Last) BENJAMIN H RICHARDS | | | 4. DATE OF DEATH (Month) (Day) (Year) 1-26-52 | | |
|---|--|--|---|--|--|

| | | | | | | |
|-----------------|---------------------------|---|-----------------------------------|---|-----------------------------|-----------------------------|
| 5. SEX M | 6. COLOR OR RACE W | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) MARRIED | 8. DATE OF BIRTH 8/19/1888 | 9. AGE (In years last birthday) 63 | IF UNDER 1 YEAR Months Days | IF UNDER 24 HRS. Hours Min. |
|-----------------|---------------------------|---|-----------------------------------|---|-----------------------------|-----------------------------|

| | | | |
|--|--|---|--|
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED | 10b. KIND OF BUSINESS OR INDUSTRY ATLAS POWDER CO | 11. BIRTHPLACE (State or foreign country) WESTFIELD ILL. | 12. CITIZEN OF WHAT COUNTRY? U.S.A. |
|--|--|---|--|

| | | |
|--|---|---|
| 13a. FATHER'S NAME SAMUEL J. RICHARDS | 13b. MOTHER'S MAIDEN NAME LEAH BOYER | 14. NAME OF HUSBAND OR WIFE RUTH M |
|--|---|---|

| | | | |
|---|-----------------------------------|---|--------------------|
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No | 16. SOCIAL SECURITY NO. No | 17. INFORMANT'S SIGNATURE OR NAME Mrs Ruth M. Richards | ADDRESS 200 |
|---|-----------------------------------|---|--------------------|

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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) Myocarditis. | | | several year |
| | ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Artero-sclerotic myocarditis. DUE TO (c) | | | |
| II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. | | | | |

| | | |
|------------------------|----------------------------------|--|
| 19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
|------------------------|----------------------------------|--|

| | | |
|--|--|---|
| 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) |
|--|--|---|

| | | |
|---|--|----------------------------|
| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | 21f. HOW DID INJURY OCCUR? |
|---|--|----------------------------|

22. I hereby certify that I attended the deceased from **Feb**, 19**51**, to **Jan 26** 19**52**, that I last saw the deceased alive on **Jan 24, 1952**, and that death occurred at _____ m., from the causes and on the date stated above.

| | | | |
|--|-------------------|---|---------------------------------|
| 23a. SIGNATURE Leod. It. McPherson M.D. | (Degree or title) | 23b. ADDRESS 607 Frisco Bldg, Joplin Mo. | 23c. DATE SIGNED 1-20-52 |
|--|-------------------|---|---------------------------------|

| | | | |
|---|-----------|---|--|
| 24a. DATE OF REMOVAL (Specify) 1/29/52 | 24b. DATE | 24c. NAME OF CEMETERY OR CREMATORY STONE POINT CEM | 24d. LOCATION (City, town, or county) (State) Joplin MO |
|---|-----------|---|--|

| | | | |
|---|--|---|---------------------------|
| DATE REC'D BY LOCAL REG. 1-29-52 | REGISTRAR'S SIGNATURE [Signature] | 25. FUNERAL DIRECTOR'S SIGNATURE GLOVER MORTUARY | ADDRESS Joplin Mo. |
|---|--|---|---------------------------|

RECEIVED 2-4-52

Jasper County Health Office

County File Number 52/2/90

Date Filed 2-4-52

APR 30 1957

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.....

Dale G. Ho

Signed.....
Student Embalmer

Licensed Embalmer No. 4593

P. O. Address *Joplin, Mo.*

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.