

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **3878**

FILED FEB 25 1952

BIRTH NO. _____ REG. DIST. NO. **2** PRIMARY REG. DIST. NO. **4009** Registrar's No. **12**

1. PLACE OF DEATH a. COUNTY Andrew		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE neb b. COUNTY Madison	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN SAVANNAH		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Northfork 8260	
c. LENGTH OF STAY (In this place)		d. STREET ADDRESS (If rural, give location) 509 S. 6th St	
d. FULL NAME OF (If not in hospital or institution, give street address or location) INSTITUTION Dr Nicholas Sanitorium			

3. NAME OF DECEASED (Type or Print) a. (First) Violet b. (Middle) R. c. (Last) Richards			4. DATE OF DEATH (Month) (Day) (Year) 2-12-1952		
5. SEX F	6. COLOR OR RACE W	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) m	8. DATE OF BIRTH Sept 19-1903	9. AGE (In years last birthday) 48	IF UNDER 1 YEAR Months Days 4 27
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) no		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Madison Co Neb	12. CITIZEN OF WHAT COUNTRY? US

13a. FATHER'S NAME John Jones		13b. MOTHER'S MAIDEN NAME Winnie Wood		14. NAME OF HUSBAND OR WIFE Rees L. Richards	
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.		17. INFORMANT'S SIGNATURE OR NAME ADDRESS Dr. P. D. Richards Wm. Neb	

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 I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Coronary Occlusion ANTECEDENT CAUSES Morbidity 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.			INTERVAL BETWEEN ONSET AND DEATH 12 hours
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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) 4201	
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?	

22. I hereby certify that I attended the deceased from **Feb 15, 1952**, to **Feb 16, 1952**, that I last saw the deceased alive on **Feb 16, 1952**, and that death occurred at **9 a. m.**, from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) W. O. Thomas, M.D.		23b. ADDRESS Savannah Mo.		23c. DATE SIGNED Feb 16-1952	
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24a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		24b. DATE 2-19-1952		24c. NAME OF CEMETERY OR CREMATORY inside one neb.		24d. LOCATION (City, town, or county) (State)	
DATE REC'D BY LOCAL REG. 2-19-52		REGISTRAR'S SIGNATURE Lillian Spaker		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Bret Funeral Home Savannah Mo.			

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

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AUG 9 1956

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 E. C. Breit

Licensed Embalmer No. 2650

P. O. Address Lawrence, 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.