

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No.

10482

FILED APR 12 1952

2793

BIRTH NO. _____ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003** Registrar's No.

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		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis 2149	
d. FULL NAME OF HOSPITAL OR INSTITUTION 6377 Bancroft avenue		d. STREET ADDRESS (If rural, give location) 6377 Bancroft avenue	

3. NAME OF DECEASED (Type or Print) ELIZABETH	a. (First)	b. (Middle)	c. (Last) RICHARDSON	4. DATE OF DEATH 3-22-52	(Month) (Day) (Year)
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5. SEX female	6. COLOR OR RACE white	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) divorced 3	8. DATE OF BIRTH 1-29-1862	9. AGE (In years last birthday) 90	IF UNDER 1 YEAR Months	IF UNDER 1 HOUR Hours	IF UNDER 1 MIN. Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) retired housewife	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and State or Foreign Country) Canada	12. CITIZEN OF WHAT COUNTRY? USA
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13a. FATHER'S NAME Thomas Richardson	13b. MOTHER'S MAIDEN NAME Janet Stratton	14. NAME OF HUSBAND OR WIFE Wm. C. Richardson
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no	16. SOCIAL SECURITY NO. none	17. INFORMANT'S SIGNATURE OR NAME Dominik Seeler	ADDRESS 6337 Bancroft ave.
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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 9 days 2 yrs 2 mos.
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Apoplexy		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Arterio sclerosis DUE TO (c) Hypertension		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			

19a. DATE OF OPERATION none	19b. MAJOR FINDINGS OF OPERATION none	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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21a. ACCIDENT SUICIDE HOMICIDE (Specify) none	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) none	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR 334X
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22. I hereby certify that I attended the deceased from **June, 1950**, to **March 22, 1952**, that I last saw the deceased alive on **March 21, 1952**, and that death occurred at **2:30 A. m.**, from the causes and on the date stated above.

23a. SIGNATURE Curtis A. Meyer M.D.	(Degree or title)	23b. ADDRESS 4952 Maryland	23c. DATE SIGNED 3/22/52
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24a. BURIAL, CREMATION, REMOVAL (Specify) removal	24b. DATE 3-22-52	24c. NAME OF CEMETERY OR CREMATORY Frankfort, Mo.	24d. LOCATION (City, town, or county) (State)
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DATE REC'D BY LOCAL REG. MAR 25 1952	REGISTRAR'S SIGNATURE [Signature]	25. FUNERAL DIRECTOR'S SIGNATURE Fields F. H.	ADDRESS Frankfort, Mo.
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(Licensed Embalmer's Statement on Reverse Side)

WRITE PLAINLY—USING UNFADING 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 Bert Hoffman

Licensed Embalmer No. 4366

P. O. Address W. St. Louis, 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.