

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **29948**
Registrar's No. **7839**

SEP 5-1952
BIRTH NO. **65263**

REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003**

1. PLACE OF DEATH a. COUNTY 0		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.) a. STATE Missouri b. COUNTY St. Louis	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St Louis		c. LENGTH OF STAY (In this place)	
d. FULL NAME OF HOSPITAL OR INSTITUTION Saint Louis Maternity		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Berkeley	
		d. STREET ADDRESS (If rural, give location) 8326 Whitewater	
3. NAME OF DECEASED (Type or Print) a. (First) William b. (Middle) E. c. (Last) Richardson			4. DATE OF DEATH (Month) (Day) (Year) August 16 1952
5. SEX Male 0	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Infant 0	8. DATE OF BIRTH August 14 1952
9. AGE (In years last birthday) 1 15 35		9. AGE (In years last birthday) 1 15 35	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY None	
11. BIRTHPLACE (City and State or Foreign Country) St Louis Missouri 0		12. CITIZEN OF WHAT COUNTRY?	
13a. FATHER'S NAME Fed Richardson		13b. MOTHER'S MAIDEN NAME Mary Matilda Topel	
14. NAME OF HUSBAND OR WIFE nil			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. nil	
17. INFORMANT'S SIGNATURE OR NAME Saint Louis Maternity Hospital		ADDRESS	
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) Atelectasis, congestion of Brain ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) of Brain 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 checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT (Specify) SUICIDE		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) (Min.)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
21f. HOW DID INJURY OCCUR? 7620			
22. I hereby certify that I attended the deceased from 8-11-1952 , to 8-16-1952 , that I last saw the deceased alive on 8-16-1952 , and that death occurred at 1:20 P.m. , from the causes and on the date stated above.			
23a. SIGNATURE F.R. Bradley (Degree or title) M.D. 0		23b. ADDRESS 600 S. Kingshighway	
23c. DATE SIGNED 8/16/52			
24a. BURIAL, CREMATION, REMOVAL (Specify) Removal 5		24b. DATE 8-16-52	
24c. NAME OF CEMETERY OR CREMATORY City		24d. LOCATION (City, town, or county) (State) Monona, Iowa	
DATE REC'D BY LOCAL REGISTRAR'S SIGNATURE AUG 18 1952		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS ALBERT H. HOPPE, 4700 Washington	

(Licensed Embalmer's Statement on Reverse Side)

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

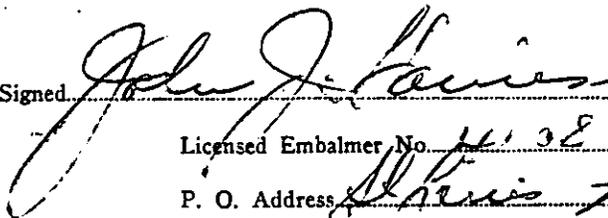
STATEMENT BY LICENSED EMBALMER

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  _____

Licensed Embalmer No. 4138

P. O. Address 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.