

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. ....

36053

FILED OCT 23 1953

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. 149 PRIMARY REG. DIST. NO. 1002 Registrar's No. 4811

1. PLACE OF DEATH a. COUNTY <u>JACKSON</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <u>MISSOURI</u> b. COUNTY <u>CLAY</u> <u>5078</u>	
b. CITY (If outside corporate limits, write RURAL and give township) <u>KANSAS CITY</u>		c. CITY (If outside corporate limits, write RURAL and give township) <u>KANSAS CITY NORTH</u>	
c. LENGTH OF STAY (In this place) <u>5 MO</u>		d. STREET ADDRESS (If rural, give location) <u>4801 EAST 44TH TERR</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>ST MARYS HOSPITAL</u>			

3. NAME OF DECEASED (Type or Print) a. (First) <u>JAMES E.</u> b. (Middle) <u>RICHARDSON</u> c. (Last) _____	4. DATE OF DEATH (Month) (Day) (Year) <u>OCT 5 1953</u>
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5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>MARRIED</u>	8. DATE OF BIRTH <u>DEC 30, 1923</u>	9. AGE (To years last birthday) Months Days <u>29</u>	IF UNDER 1 YEAR Days	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) <u>ASSEMBLER</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>FORD MOTOR CO</u>	11. BIRTHPLACE (State or foreign country) <u>SEYMOUR, MO. D</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
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13a. FATHER'S NAME <u>LE ROY RICHARDSON</u>	13b. MOTHER'S MAIDEN NAME <u>NETTIE ANDERSON</u>	14. NAME OF HUSBAND OR WIFE <u>RIVA J RICHARDSON</u>
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or date of service) <u>yes WW II</u>	16. SOCIAL SECURITY NO. <u>786-24-0774</u>	17. INFORMANT'S SIGNATURE OR NAME <u>MRS RIVA RICHARDSON</u>	ADDRESS <u>K.C. 16, MO.</u>
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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) <u>Atelectasis</u>		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Post Operative</u> DUE TO (c) <u>Pneumonectomy</u>		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death <u>Post Operative Hemorrhage - Internal</u>			

19a. DATE OF OPERATION <u>10/3/53</u>	19b. MAJOR FINDINGS OF OPERATION <u>Chronic fibrocaceous Pulmonary Tuberculosis</u>	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" 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) m.	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?
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22. I hereby certify that I attended the deceased from \_\_\_\_\_, 19\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_, that I last saw the deceased alive on \_\_\_\_\_, 19\_\_\_\_, and that death occurred at \_\_\_\_\_ m., from the causes and on the date stated above.

23a. SIGNATURE <u>Angelo Lapi</u> (Degree or title) <u>MD</u>	23b. ADDRESS <u>101 Memorial Drive</u>	23c. DATE SIGNED <u>10/5/53</u>
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24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	24b. DATE <u>10-6-53</u>	24c. NAME OF CEMETERY OR CREMATORY <u>-</u>	24d. LOCATION (City, town, or county) (State) <u>Omaha, nebr.</u>
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DATE REC'D BY LOCAL REG. <u>10-6-53</u>	REGISTRAR'S SIGNATURE <u>Seraldine Smith</u>	25. FUNERAL DIRECTOR'S SIGNATURE <u>D. W. NEWCOMER'S SONS</u>	ADDRESS <u>N.K.C. MO.</u>
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

MAR 4 1954

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

*Glen Hill*

Licensed Embalmer No. 4586

P. O. Address R.C. 16, 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.

OCT 23 1953

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State File No. 36053

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. 192 PRIMARY REG. DIST. NO. 1002 Registrar's No. 4811

1 PLACE OF BIRTH  
a COUNTY Jackson

2 USUAL RESIDENCE Where deceased lived if institution residence before death  
a STATE MISSOURI b COUNTY CLAY c CITY (if complete corporate limits, write BURIAL and give township) 57278  
OR TOWN KANSAS CITY NORTH

3 FULL NAME OF DECEASED (If not in hospital or institution, give street address or locality)  
ST MARYS Hospital

4 STREET ADDRESS (If exact, give location)  
4801 EAST 44TH TERR

5 NAME OF DECEASED (Last, First, Middle)  
JAMES E. RICHARDSON

6 DATE OF DEATH (Month) (Day) (Year)  
OCT 5 1953

7 SEX MALE 8 COLOR OR RACE WHITE 9 MARRIED NEVER MARRIED, WIDOWED, DIVORCED, SEPARATED MARRIED 10 DATE OF BIRTH (Month) (Day) (Year)  
Dec 30, 1922 29

11 USUAL OCCUPATION (Give kind of work for most of working life, even if retired) ASSEMBLER 12 KIND OF BUSINESS OR INDUSTRY FORD MOTOR CO 13 BIRTHPLACE (State or foreign country) SEYMOUR, Mo. 14 CITIZEN OF WHAT COUNTRY? U.S.A.

15a. FATHER'S NAME Le Roy Richardson 15b. MOTHER'S maiden name Nattie Anderson 15c. NAME OF MARRIED OR WIFE Elizabeth Richardson

16 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give year or years of service) yes WW II 17 SOCIAL SECURITY NUMBER 486-24-074 18 INFORMANT'S SIGNATURE OR NAME Mrs R. H. Richardson ADDRESS Omaha, Neb.

19 CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)  
MEDICAL CERTIFICATION  
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH\* (a) Atelectasis Items 14 & 17 corrected  
ANTECEDENT CAUSE: by an affidavit from  
Advised conditions, if any, giving rise to the above cause (1) during the underlying cause last  
DUE TO (b) Post Operative Informant-  
DUE TO (c) Circumstances 5-12-66  
20 OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death  
Post Operative Hemorrhage Internal  
21 MAJOR FINDINGS OF OPERATION  
Chronic fibrocavous Pulmonary Tuberculosis 22 AUTOPSY?  YES  NO

23 DATE OF OPERATION  
10/3/53

24a ACCIDENT SUICIDE HOMICIDE (Specify) \_\_\_\_\_ 24b PLACE OF INJURY (If in street, house, farm, factory, ocean, etc., give locality) \_\_\_\_\_ 24c (CITY, TOWN OR TOWNSHIP) (COUNTY) (STATE) \_\_\_\_\_

25 TIME (Month) (Day) (Year) (Hour) \_\_\_\_\_ 25a INJURY OCCURRED WHILE AT WORK?  YES  NO 25b HOW DID INJURY OCCUR? \_\_\_\_\_

26 I hereby certify that I attended the deceased from \_\_\_\_\_ 19\_\_\_\_, to \_\_\_\_\_ 19\_\_\_\_, that I last saw the deceased alive on \_\_\_\_\_ 19\_\_\_\_ and that death occurred at \_\_\_\_\_ m. from the cause and on the day's stated above.

27 SIGNATURE AND TITLE (Physician only) \_\_\_\_\_ 28 ADDRESS \_\_\_\_\_ 29 DATE SIGNED \_\_\_\_\_  
Sheldine Smith 101 Memorial Drive 10/5/53

30 BURIAL CHURCH (If not in institution, give name) \_\_\_\_\_ 31 DATE \_\_\_\_\_ 32 HAVE DECEASED BY OPERATOR?  YES  NO 33 LOCATION (City, County, State) (Specify)  
Omaha, Neb.

34 DATE RECD BY LOCAL HEALTH DEPARTMENT \_\_\_\_\_ 35 REGISTRAR'S SIGNATURE \_\_\_\_\_ 36 PUBLIC HEALTH DIRECTOR'S SIGNATURE \_\_\_\_\_ ADDRESS \_\_\_\_\_  
10-6-53 Sheldine Smith D. W. DeWitt's Sons N.C. Mo.

WRITE PLAINLY—USING UNFADING INK—MAKE A PERMANENT RECORD