

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

FILED JAN 6 1956

State File No. **42543**BIRTH NO. _____ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003** Registrar's No. **10701**

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) ST. LOUIS, MISSOURI		c. LENGTH OF STAY (In this place)		c. CITY OR TOWN St. Louis,		d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input type="checkbox"/>	
d. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION ST. LOUIS CITY HOSPITAL # 1.				e. STREET ADDRESS (If rural, give location) 2611 N. Spring Ave. <i>2119d</i>			
3. NAME OF DECEASED (Type or Print) a. (First) RUTH		b. (Middle) Louise		c. (Last) RICHARDSON		4. DATE OF DEATH (Month) (Day) (Year) DECEMBER 5, 1955.	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH July 12, 1886		9. AGE (In years last birthday) 69	IF UNDER 1 YEAR Months Days	IF UNDER 14 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY At Home,		11. BIRTHPLACE (City and State or Foreign Country) Corning, Arkansas		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13a. FATHER'S NAME Charles W. Robison		13b. MOTHER'S MAIDEN NAME Alcey Norris		14. NAME OF HUSBAND OR WIFE Timothy Richards on			
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. Nil.		17. INFORMANT'S SIGNATURE OR NAME ADDRESS Alma Thompson, 3278 Regal Pl.			
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, ashenia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH 3 hrs.
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <i>personal arrhythmia tachycardia</i>						
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <i>coronary arterio sclerosis</i>						
	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 420.1				20. AUTOPSY? / YES <input checked="" type="checkbox"/> NO <input 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 11-16 , 19 55 , to 12-5 , 19 55 , that I last saw the deceased alive on 12-5 , 19 55 , and that death occurred at 11:10a m., from the causes and on the date stated above.							
23a. SIGNATURE (Degree or title) <i>E. R. Schuff</i> E. R. Schuff, M.D.				23b. ADDRESS 1515 LAFAYETTE AVE.		23c. DATE SIGNED 12-5-55.	
24a. BURIAL, CREMATION, REMOVAL (Specify) Removal		24b. DATE 12-6-55	24c. NAME OF CEMETERY OR CREMATORY Local		24d. LOCATION (City, town, or county) (State) Iron ton, Mo.		
DATE REC'D BY LOCAL REG. DEC 6 1955		REGISTRAR'S SIGNATURE <i>J. Carl Smith M.D.</i>		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.....
Signature of Student Embalmer

Signed *Robert M. Murray*.....
Licensed Embalmer No.....

P. O. Address *St. Louis*.....

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 embalmed by a **STUDENT**, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.