

FILED JUN 4 1956

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **15857**
Registrar's No. **58**

BIRTH NO. _____ REG. DIST. NO. **75** PRIMARY REG. DIST. NO. **3015**

1. PLACE OF DEATH a. COUNTY Clinton		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before death.) a. STATE MO. b. COUNTY CLINTON	
b. CITY OR TOWN CAMERON MO.	c. LENGTH OF STAY (in this place) 5 yrs.	c. CITY OR TOWN RURAL RID. I	d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
d. FULL NAME OF HOSPITAL OR INSTITUTION CAMERON Community Hosp.		f. STREET ADDRESS (If rural, give location) 6 Miles S-W-CAMERON	

3. NAME OF DECEASED (Type or Print) a. (First) William b. (Middle) Peath c. (Last) Richardson	4. DATE OF DEATH (Month) (Day) (Year) 5 20 56					
5. SEX F	6. COLOR OR RACE W	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) MARRIED	8. DATE OF BIRTH Feb 11 1885	9. AGE (In years last birthday) 71	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 4 HRS. Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work during most of working life, even if retired) House wife	10b. KIND OF BUSINESS OR INDUSTRY SELF	11. BIRTHPLACE (City and State or Foreign Country) Clinton County MO	12. CITIZEN OF WHAT COUNTRY? USA			

13a. FATHER'S NAME Edward A. Rice	13b. MOTHER'S MAIDEN NAME MARY A. Henderson	14. NAME OF HUSBAND OR WIFE Boyd Richardson
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 Boyd Richardson ADDRESS CAMERON

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, asphyxia, etc. It means the disease, injury, or complication which caused death.	1. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral Hemorrhage		INTERVAL BETWEEN ONSET AND DEATH 2 hrs
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____		
	11. 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 331X	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)
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 **1996**, 19____, to **5-19**, 19**56** that I last saw the deceased alive on **5-19**, 19**56**, and that death occurred at **7 A** m., from the causes and on the date stated above.

23a. SIGNATURE W. Kerner (Degree or title) MD	23b. ADDRESS Cameron MO	23c. DATE SIGNED 5-22-56
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24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE 5-22-56	24c. NAME OF CEMETERY OR CREMATORY Graceland Cemetery	24d. LOCATION (City, town, or county) (State) Cameron MO
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DATE REC'D BY LOCAL REG 5-28-56	REGISTRAR'S SIGNATURE Winifred W. Moser	FUNERAL DIRECTOR'S SIGNATURE Robert H. Toland	ADDRESS Cameron MO
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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 Z Poloud

Licensed Embalmer No... 47
222
P. O. Address... C. Am...

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.