

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

36085

STATE FILE NUMBER

FILED NOV 16 1956

Registration District No. 318 Primary Registration District No. 1003

Registrar's No. 9868

1300
1-56
0
 USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE
 Doctor, coroner, etc., must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be casually related. Coroner cannot certify to a death due to natural causes.

1. PLACE OF DEATH a. COUNTY				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Kansas b. COUNTY Anderson			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN Colony		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Mo. Baptist Hospital			Length of stay in 1b	d. STREET ADDRESS (If outside, give location)			Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Pamela Middle D. Last Richardson				4. DATE OF DEATH Month Oct. Day 28 Year 1956			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH June 6, 1953		9. AGE (In years last birthday) 3 IF UNDER 1 YEAR: Months _____ Days _____ IF UNDER 24 HRS.: Hours _____ Min. _____	
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 country) Sikeston, Mo.		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Donald Richardson				14. MOTHER'S MAIDEN NAME Hilda Smith			
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. None		17. INFORMANT Donald Richardson, Colony, Kansas. Address _____			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hydrocephalus <i>Hydrocephalus</i> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH 3 yrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) .752 +				
20c. TIME OF INJURY Hour _____ Month _____ Day _____ Year _____ a. m. _____ p. m. _____							
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION 10-28-56		COUNTY _____ STATE _____	
21. I attended the deceased from Birth to 28 Oct 1956 and last saw her alive on 28 Oct 56 Death occurred at 2:20 p. m. on the date stated above; and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE <i>Robert W. Woolsey</i>			22b. ADDRESS 6911 Chaffin St. D. Anderson, Mo.			22c. DATE SIGNED OCT 29	
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal		23b. DATE 10-29-56	23c. NAME OF CEMETERY OR CREMATORY Local		23d. LOCATION (City, town, or county) (State) Colony, Kansas		
24. FUNERAL DIRECTOR Albert H. Hoppe, 4700 Washington Blvd.				25. DATE RECD. BY LOCAL REG. OCT 29 1956		26. REGISTRAR'S SIGNATURE <i>Carl Smith</i>	

(Licensed Embalmer's Statement on Reverse Side)

mdb

No. _____ Date _____
 Name of Deceased _____
 Address _____
 City _____ State _____
 County _____
 Age _____ Sex _____
 Race _____
 Cause of Death _____
 Place of Death _____
 Name of Physician _____
 Name of Coroner _____
 Name of Undertaker _____
 Name of Embalmer _____
 Name of Student _____
 Name of Assistant _____
 Name of Embalmer _____
 Name of Student _____
 Name of Assistant _____

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 *Stanley H. A...*
 Licensed Embalmer No. _____
 P. O. Address *St. L.*

Note: The above **MUST BE SIGNED BY THE LICENSED EMBALMER** in his **OWN HANDWRITING**. (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.