FILED NOV 26 1956

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

STATE FILE NUMBER 37129

Registration District No. 42 Primary Registration District No. 1000 Registrar's No. 1224

1. PLACE OF DEATH
a. COUNTY Buchanan
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Joseph — Inside Limits Yes ☒ No ☐
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 1921 Faraon St. — Length of stay in Ib 67 years

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Missouri b. COUNTY Buchanan
c. CITY OR TOWN St. Joseph — Inside Limits Yes ☒ No ☐
d. STREET ADDRESS 1921 Faraon St. (If outside, give location) — Reside on Farm Yes ☐ No ☐

3. NAME OF DECEASED (Type or print): First SAMUEL Middle ROSS Last RICHARDSON
4. DATE OF DEATH Month Nov. Day 15 Year 1956
5. SEX male
6. COLOR OR RACE white
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH July 1, 1879
9. AGE (In years last birthday) 77 — 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) Ret. Motorman
10b. KIND OF BUSINESS OR INDUSTRY Street Railway Co.
11. BIRTHPLACE (City and state or country) Milan, Mo.
12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME John Ross Richardson
14. MOTHER'S MAIDEN NAME Mollie Coons
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) yes (If yes, give war or dates of service) Spanish American
16. SOCIAL SECURITY NO. 491-09-7289
17. INFORMANT Mrs. Bertha Richardson, Address 1921 Faraon St. St. Joseph, Mo.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cardiac decompensation — INTERVAL BETWEEN ONSET AND DEATH 1 week
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b) Arteriosclerotic heart disease — 10 years
DUE TO (c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 4200

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year
20d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
20f. CITY, TOWN, OR LOCATION COUNTY STATE

21. I attended the deceased from May 1947, to Nov. 1956 and last saw her/him alive on 13 Nov. 56
Death occurred at 9:50p. m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE Walter C. McDonald (Degree or title) M.D.
22b. ADDRESS 301 N. 8th St., St. Joseph Mo.
22c. DATE SIGNED 19 Nov. 56

23a. BURIAL, CREMATION, REMOVAL (Specify) burial
23b. DATE 11/17/1956
23c. NAME OF CEMETERY OR CREMATORY Mt. Auburn Cemetery
23d. LOCATION (City, town, or county) St. Joseph, Mo. (State)

24. FUNERAL DIRECTOR Weston-Bowman ADDRESS St Joseph Mo
25. DATE RECD. BY LOCAL REG. Nov. 23, 1956
26. REGISTRAR'S SIGNATURE Esther M. Allison

(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

diseases in Part I must be casually related. Coroner cannot certify to a death due to natural causes.

NOV 27 1958

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was e

by me, or by ....., Student Embalmer No.....

working under my personal supervision..

Student.....
Signature of Student Embalmer

Signed James P. Hawkins

Licensed Embalmer No. 4.

P. O. Address 319 Ro 10

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.