XC 19780349 SL 9392

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

19208
STATE FILE NUMBER

FILED JUN 14 1957 Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 5253

1. PLACE OF DEATH
a. COUNTY
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis — Inside Limits Yes [X] No [ ]
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION VA HOSPITAL — Length of stay in lb 25 days
35

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Illinois COUNTY St. Clair
c. CITY OR TOWN E. St. Louis — Inside Limits Yes [X] No [ ]
d. STREET ADDRESS (If outside, give location) 4240 Tudor — Reside on Farm Yes [ ] No [X]
32 8120

3. NAME OF DECEASED (Type or print) First Middle Last: Will Richardson
4. DATE OF DEATH Month Day Year: 6-2-57

5. SEX: Male 2
6. COLOR OR RACE: Negro
7. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]
8. DATE OF BIRTH: 5/5/1896
9. AGE (In years last birthday): 60 — 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): Laborer
10b. KIND OF BUSINESS OR INDUSTRY: Unknown
11. BIRTHPLACE (City and state or country): Starkville, Miss.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Murray Richardson
14. MOTHER'S MAIDEN NAME: Sophia Wright

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes — (If yes, give war or dates of service) WWI
16. SOCIAL SECURITY NO.: Unknown
17. INFORMANT Address: VAH HOSPTIAL RECORDS, ST. LOUIS, 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) Massive cerebral infarction — INTERVAL BETWEEN ONSET AND DEATH: Unk.
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b) Thrombosis of right middle cerebral artery — Unk.
DUE TO (c) Generalized arteriosclerosis — Unk.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): 332x
19. WAS AUTOPSY PERFORMED? YES [X] 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. VA attended the deceased from 5-8-57, to 6-2-57 and last saw ~~XX~~ him alive on 6-2-57
Death occurred at 9:45 A m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE R. W. Burmeister, M.D. — R. W. Burmeister M.D.
22b. ADDRESS: VAH, ST. LOUIS, MO.
22c. DATE SIGNED: 6-2-57

23a. BURIAL, CREMATION, REMOVAL (Specify): Removal
23b. DATE: 6/6/1957
23c. NAME OF CEMETERY OR CREMATORY: National Cemetery
23d. LOCATION (City, town, or county) (State): Jefferson Barrcks, Mo.

24. FUNERAL DIRECTOR ADDRESS: G. Wade Granberry 4202 Finney Ave.
25. DATE RECD. BY LOCAL REG.: JUN 4 '57
26. REGISTRAR'S SIGNATURE: J Earl Smith MD MJB

(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

STATEMENT BY LICENSED EMBALMER

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

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

working under my personal supervision..

Student.....
Signature of Student Embalmer

Signed Leroy U. Bannister

Licensed Embalmer No 45

P. O. Address 4251 Was

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.