

Health,  
Welfare  
Public  
Service

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

58-011011  
STATE FILE NUMBER

FILED APR 7 1958

Registration District No. 276 Primary Registration District No. 4410 Registrar's No. 22

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-57  
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1. PLACE OF DEATH a. COUNTY Phelps		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Phelps	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. James		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN St. James
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION None		Length of stay in 1b	d. STREET ADDRESS (If outside, give location) 601 W. Washington
3. NAME OF DECEASED (Type or print) First Middle Last Grover Cleveland Richardson			4. DATE OF DEATH Month Day Year March 28, 1958
5. SEX Male	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 Sept. 5, 1884
9. AGE (In years last birthday) 73	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Labor	11. BIRTHPLACE (City and state or country) Missouri	12. CITIZEN OF WHAT COUNTRY? U.S.A.
13a. FATHER'S NAME Alfred Richardson		13b. MOTHER'S MAIDEN NAME Lovance Richardson	14. NAME OF HUSBAND OR WIFE
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no none		16. SOCIAL SECURITY NO. 488-28-D39	17. INFORMANT Address Minnie Fore 213 E. 9th, Rolla, Mo.
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Natural Causes DUE TO (b) Senility DUE TO (c) 794X PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)			INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT SUICIDE HOMICIDE <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)	
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 COUNTY STATE
21. I attended the deceased from _____ to _____ and last saw <sup>him</sup> <del>her</del> alive on <u>dead</u> Death occurred at <u>1:00</u> a m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) Ruth B. Powell Local Registrar		22b. ADDRESS St. James, Mo	22c. DATE SIGNED 3-28-58
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 3/30/58	23c. NAME OF CEMETERY OR CREMATORY Masonic Cemetery	23d. LOCATION (City, town, or county) (State) St. James, Missouri
24. FUNERAL DIRECTOR Jesse Gahr		ADDRESS St. James, Mo.	25. DATE RECD. BY LOCAL REG. March 28, 1958
26. REGISTRAR'S SIGNATURE Ruth B. Powell			

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

Doctor, Cause of death must be causally related. All diseases in Part I must be causally related.

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 *C. Jesse Gahr* .....

Licensed Embalmer No. *4486* .....  
P. O. Address *St. James* .....

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.