

Health,
& Welfare
Public
Service

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-034624
STATE FILE NUMBER 9194

FILED OCT 10 1958

Registration District No. 318 Primary Registration District No. 1003 Registrar's No.

S. 300
1-57

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY	
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 St. Louis Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 01 2614 BERNARD		Length of stay in lb 2 yrs 2229	d. STREET ADDRESS (If outside, give location) 2614 BERNARD Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First Middle Last James Richardson			4. DATE OF DEATH Month Day Year Sept 26, 1958			
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5. SEX Male ²	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct 21, 1903	9. AGE (In years last birthday) 55	F UNDER 1 YEAR Months Days Hours Min.	I IF UNDER 24 HRS.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer	10b. KIND OF BUSINESS OR INDUSTRY Unemployed	11. BIRTHPLACE (City and state or country) Marrianna, Arkansas	12. CITIZEN OF WHAT COUNTRY? U. S. A.
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13. FATHER'S NAME James Richardson, Sr	13b. MOTHER'S MAIDEN NAME Lula Baskin	14. NAME OF HUSBAND OR WIFE None
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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. Unknown	17. INFORMANT Lula Bowers	Address 2675 Scott St. Louis, Mo.
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Basilar Skull fracture with subdural and subarachnoid hemorrhage and partial hemorrhage		INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) E900.0 2	
	DUE TO (c)	

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Following fall down		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
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20a. ACCIDENT <input checked="" 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.) Slips at home on September 4th, 1958.
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20c. TIME OF INJURY Hour a.m. p.m. 9 4 58	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.) 22 Home	20f. CITY, TOWN, OR LOCATION St. Louis Mo	COUNTY	STATE
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21. I attended the deceased from Death occurred at 350 A m on the date stated above; and to the best of my knowledge, from the causes stated.	and last saw her alive on
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22a. SIGNATURE James M Kelly (Name or title) Deputy Clerk	22b. ADDRESS 1300 Clark	22c. DATE SIGNED 9-24-58
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23a. BURIAL CREMATION, REMOVAL (Specify) Burial	23b. DATE 9/27/58	23c. NAME OF CEMETERY OR CREMATORY Father Duxson	23d. LOCATION (City, town, or county) (State) St. Louis Co, Missouri
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24. FUNERAL DIRECTOR Marion's Office	ADDRESS 2114 Mo. Ave. St. Louis, Mo.	25. DATE RECD. BY LOCAL REG. SEP 24 '58	26. REGISTRAR'S SIGNATURE J. Carl Smith, M.D. S.P.
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(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE
MEDICAL CERTIFICATION
Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. 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 *Frank Proff*

Licensed Embalmer No. *4356*

P. O. Address *S. L. ...*

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.