

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

58-036767

STATE FILE NUMBER

FILED NOV 5 1958 Registration District No. 146 Primary Registration District No. 5568 Registrar's No. 452

S. 300  
1-57

|  |                               |  |  |
|--|-------------------------------|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Jackson</u>  |                               | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <u>Missouri</u> b. COUNTY <u>Jackson</u>               |  |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Blue</u>  |                               | c. CITY OR TOWN <u>Kansas City Mo</u>  |  |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>528 So. Huttig</u>  |                               | d. STREET ADDRESS (If outside, give location) <u>528 So Huttig</u>   |  |
| 3. NAME OF DECEASED (Type or print) First <u>Marie</u> Middle <u>J.</u> Last <u>Richter</u>  |                               | 4. DATE OF DEATH Month <u>Oct.</u> Day <u>24</u> Year <u>1958</u>  |  |
| 5. SEX <u>Female</u>   | 6. COLOR OR RACE <u>white</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>Oct. 1. 1874</u>   |
| 9. AGE (In years last birthday) <u>84</u>  |                               | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>domestic</u>   |  |
| 11. BIRTHPLACE (City and state or country) <u>Burlington Iowa</u>  |                               | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u>  |  |
| 13a. FATHER'S NAME <u>Adolph Richter</u>   |                               | 13b. MOTHER'S MAIDEN NAME <u>Lydia Bauer</u>   |  |
| 14. NAME OF HUSBAND OR WIFE <u>none</u>  |                               | 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>                                      |  |
| 16. SOCIAL SECURITY NO. <u>none</u>  |                               | 17. INFORMANT Address <u>Mrs. Hattie St. John - 528 So Huttig</u>  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Bronchial Pneumonia</u><br>Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Senility</u><br>DUE TO (c) <u>491X</u> |                               |  | INTERVAL BETWEEN ONSET AND DEATH <u>3 years</u>  |
| 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 type="checkbox"/> NO <input checked="" 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.)   |  |
| 20c. TIME OF INJURY Hour <u>          </u> Month, Day, Year <u>          </u> a.m. <u>          </u> p.m. <u>          </u>  |                               |  |  |
| 20d. INJURY OCCURRED WHILE AT <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 <u>Oct 16 - 58</u> to <u>Oct 23/58</u> and last saw her alive on <u>Oct 23/58</u><br>Death occurred at <u>Oct 24 - 58 2:40 Pm</u> on the date stated above; and to the best of my knowledge, from the causes stated.  |                               |  |  |
| 22a. SIGNATURE <u>Fred W. Hubert MD.</u> (Doctor or Title)   |                               | 22b. ADDRESS <u>10229 Redeye Ave</u>   |  |
|  |                               | 22c. DATE SIGNED <u>10-25-58</u>   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>  |                               | 23b. DATE <u>Oct-27-58</u>   |  |
| 23c. NAME OF CEMETERY OR CREMATORY <u>Mound Grove</u>  |                               | 23d. LOCATION (City, town, or county) (State) <u>Jackson Mo.</u>   |  |
| 24. FUNERAL DIRECTOR <u>Soland R. Speerke</u> ADDRESS <u>          </u>  |                               | 25. DATE RECD. BY LOCAL REG. <u>10-27-58</u>   |  |
|  |                               | 26. REGISTRAR'S SIGNATURE <u>James Craig</u>   |  |

All diseases in Part I must be causally related. No symptoms will be listed.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

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 *Paul B. Jenkins* .....  
Licensed Embalmer No. *3604* .....  
P. O. Address *Indip* .....

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.