

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-043638
STATE FILE NUMBER

FILED JAN 6 1959 Registration District No. 93 Primary Registration District No. _____ Registrar's No. 58-88

1. PLACE OF DEATH a. COUNTY <u>Dade</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>Dade</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>North twp.</u> Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN <u>Arcola</u> Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>2 mi. E. of Arcola</u> Length of stay in 1b <u>11 years</u>		d. STREET ADDRESS (If outside, give location) <u>2 mi. East</u> Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED First Middle Last <u>Lee - Richardson</u>			4. DATE OF DEATH Month Day Year <u>Dec. 26, 1958</u>
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept. 8, 1901</u>
9. AGE (In years last birthday) <u>57</u>		IF UNDER 1 YEAR Months Days Hours	IF UNDER 24 HRS. Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farm</u>	11. BIRTHPLACE (City and state or country) <u>Hamilton County, Ill.</u>
12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>		13a. FATHER'S NAME <u>Wm Carroll Richardson</u>	
13b. MOTHER'S MAIDEN NAME <u>Emily Jane Adams</u>		14. NAME OF HUSBAND OR WIFE <u>Gladys L. Richardson</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>491-38-6611</u>	
17. INFORMANT <u>Mrs. Gladys L. Richardson; Arcola, Mo.</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>apoplexy</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) _____ DUE TO (c) _____			INTERVAL BETWEEN ONSET AND DEATH <u>334x</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 Month, Day, Year a.m. p.m.			
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>12-23-58</u> to <u>Dec. 26, 1958</u> and last saw ^{him} alive on <u>Dec 26-58</u> Death occurred at <u>6:55</u> p. m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <u>W. O. Cowan M.D.</u>		22b. ADDRESS <u>Greenfield, Mo.</u>	
22c. DATE SIGNED <u>12-28-58</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>Dec. 28, 1958</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Hickory Grove Cem.</u>		23d. LOCATION (City, town, or county) (State) <u>Dade County, Mo.</u>	
24. FUNERAL DIRECTOR <u>J. C. Canada, Greenfield, Mo.</u>		25. DATE RECD. BY LOCAL REG. <u>12/28/1958</u>	
26. REGISTRAR'S SIGNATURE <u>J. C. Canada</u>			

W.O. COWAN, M.D. USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

1-57
300
18
0
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 *J. C. Canada*.....

Licensed Embalmer No. *4196*.....
P. O. Address *Greenfield, Va*.....

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.