Health, Welfare Public Service

300 C -57

THE DIVISION OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

59-002068
STATE FILE NUMBER

FILED FEB 3 1959

Registration District No. 100 Primary Registration District No. 3041 Registrar's No. 23

1. PLACE OF DEATH
a. COUNTY: Macon
b. CITY OR TOWN (If outside corporate limits, give TOWNSHIP only): Macon — Inside Limits: Yes [X] No [ ]
c. FULL NAME OF HOSPITAL OR INSTITUTION: Samaritan — Length of stay in Hospital: 1 day

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Mo — COUNTY: Macon
c. CITY OR TOWN: Callao — Inside Limits: Yes [ ] No [X]
d. STREET ADDRESS (If outside, give location): R F D — Reside on Farm: Yes [X] No [ ]

3. NAME OF DECEASED (Type or print): First: Ida — Middle: — Last: Richardson

4. DATE OF DEATH: Month 1 Day 23 Year 1959

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]
8. DATE OF BIRTH: 12-2-94
9. AGE (In years last birthday): 64 — 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): Domestic
10b. KIND OF BUSINESS OR INDUSTRY: —
11. BIRTHPLACE (City and state or country): New Boston Mo
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13a. FATHER'S NAME: Thomas Barnes
13b. MOTHER'S MAIDEN NAME: Ann Richardson
14. NAME OF HUSBAND ~~OR WIFE~~: Charley Richardson

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: —
17. INFORMANT: Charley Richardson — Address: Callao 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): Diabetic Coma
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b): Virus pneumonia
DUE TO (c):
INTERVAL BETWEEN ONSET AND DEATH:
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a): 260.X
19. WAS AUTOPSY PERFORMED? YES [ ] 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. I attended the deceased from 2-21-58, to 1-23-59 and last saw her/him alive on 1-22-59
Death occurred at 3 30 AM on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title): Frank H. Coffin D.O.
22b. ADDRESS: Vine St, Macon
22c. DATE SIGNED: 1-27-59

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE: 1-25-59
23c. NAME OF CEMETERY OR CREMATORY: Mt Gilead Cem
23d. LOCATION (City, town, or county) (State): Callao Mo

24. FUNERAL DIRECTOR: B. J. Edwards — ADDRESS: Bevier Mo
25. DATE RECD. BY LOCAL REG.: 1/30/59
26. REGISTRAR'S SIGNATURE: Ruth McCreely

(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

All diseases in Part I must be causally related.

Date Filed ....2-2-61.....

(2)

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 [signature] .....

Licensed Embalmer No. 1961 .....

P. O. Address Rivers, Mo. .....

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.