

Health,
Welfare
Public
Service

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-019561
STATE FILE NUMBER

FILED JUN 4 1959 Registration District No. Primary Registration District No. Registr. No. 2 4989

300
1-57

1/0

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo. b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis		c. CITY OR TOWN St. Louis	
Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 6415 Devonshire Ave.		d. STREET ADDRESS (If outside, give location) 6415 Devonshire Ave.	
Length of stay in 1b		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First MARGARET Middle Last RICHEY			4. DATE OF DEATH Month May Day 22 Year 1959		
--	--	--	--	--	--

5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 10, 1902	9. AGE (In years by birthday) 56	10. F UNDER 1 YEAR Months Days	11. F UNDER 24 HRS. Hours Min.
------------------	---------------------------	---	-----------------------------------	-------------------------------------	-----------------------------------	-----------------------------------

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) Cross Plains, Tennessee	12. CITIZEN OF WHAT COUNTRY? U.S.A.
--	-----------------------------------	---	--

13a. FATHER'S NAME William P. Gourley	13b. MOTHER'S MAIDEN NAME Anice Payne	14. NAME OF HUSBAND OR WIFE Late Charles G. Richey
--	--	---

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) No None	16. SOCIAL SECURITY NO. 498-20-9282	17. INFORMANT Mrs. Charles A. Mogab	Address shire Ave. 6415 Devon-
---	--	--	-----------------------------------

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>Carcinoma of lung</u>		INTERVAL BETWEEN ONSET AND DEATH 9 months
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) _____	163x
	DUE TO (c) _____	
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>Nov 3, 1953</u> to <u>May 22, 1959</u> and last saw her alive on <u>May 22, 1959</u> Death occurred at <u>2:30 AM</u> on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <u>John S. Matthew M.D.</u> (Degree or title)	22b. ADDRESS <u>3707 Watson Rd</u>	22c. DATE SIGNED <u>5-22-59</u>
---	---------------------------------------	------------------------------------

23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE May 25, 1959	23c. NAME OF CEMETERY OR CREMATORY Resurrection Cemetery	23d. LOCATION (City, town, or county) (State) St. Louis Co. Mo.
--	---------------------------	---	--

24. FUNERAL DIRECTOR Kriegshauser 4228 S. Kingshighway	ADDRESS	25. DATE RECD. BY LOCAL REG. MAY 22 '59	26. REGISTRAR'S SIGNATURE <u>Lead Smith. M.D.</u> mcb
---	---------	--	---

All diseases in Part I must be causally related.

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 *William B. White*

Licensed Embalmer No. *5291*

P. O. Address *2220 Kingsley*

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.