

# URI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-035883

RECORDED & INDEXED OCT 26 1959

STATE FILE NUMBER

Registration District No. 128 Primary Registration District No. 2000 Registrar's No. 1124

1. PLACE OF DEATH a. COUNTY <b>Greene</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>Greene</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Springfield</b>		c. CITY OR TOWN <b>Springfield</b>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>1339 N. Sherman</b>		d. STREET ADDRESS (If outside, give location) <b>1339 N. Sherman</b>	

3. NAME OF DECEASED (Type or print) First <b>JESSE</b> Middle <b>G.</b> Last <b>RICHARDSON</b>			4. DATE OF DEATH Month <b>October</b> Day <b>19</b> Year <b>1959</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>2 July 1889</b>	9. AGE (last birthday) <b>70</b>	IF UNDER 1 YEAR Months	IF UNDER 24 HR Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Railroad Conductor</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Retired</b>		11. BIRTHPLACE (City and state or country) <b>Missouri</b>		12. CITIZEN OF WHAT COUNTRY <b>USA</b>
13a. FATHER'S NAME <b>Tobe Richardson</b>		13b. MOTHER'S MAIDEN NAME <b>Mary Harwood</b>		14. NAME OF HUSBAND OR WIFE <b>Hassie Richardson</b>		

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>	16. SOCIAL SECURITY NO. <b>Unknown</b>	17. INFORMANT <b>Mrs. Raymond Blankenship</b>	Address <b>Springfield, Mo.</b>
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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) <b>Acute, severe pulmonary edema</b>		INTERVAL BETWEEN ONSET AND DEATH <b>Sudden</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <b>Chronic Cardiovascular Renal Disease</b>	<b>approx. 9 yrs.</b>
	DUE TO (c) <b>Severe Asthma + Bronchiectasis</b>	<b>approx 7 yrs.</b>

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>And for 1-2 yrs. General debility and Malnutrition</b>		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
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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 _____ a.m. _____ p.m. Month, Day, Year _____		

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.)	20f. CITY, TOWN, OR LOCATION <b>Springfield</b>	COUNTY <b>Greene</b>	STATE <b>Missouri</b>
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21. I attended the deceased from 1947 to 10/19/59 and last saw him alive in Sept. 1959.  
Death occurred at Approx. 12:10 A.m. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <b>Harris S. Kuehl, MD</b>	(Degree or title)	22b. ADDRESS <b>1630 N. Jefferson Springfield, Missouri</b>	22c. DATE SIGNED <b>10/20/59</b>
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23a. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>Oct. 22, 1959</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Marshfield Cemetery</b>	23d. LOCATION (City, town, or county) (State) <b>Marshfield, Missouri</b>
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24. FUNERAL DIRECTOR <b>KLINGNER MORTUARY, INC.</b>	ADDRESS <b>436 E. Pacific</b>	25. DATE RECD. BY LOCAL REG. <b>10-21-59</b>	26. REGISTRAR'S SIGNATURE <b>Effie S. Melton</b>
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DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

1957 FEB 18 10 11 AM

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**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by \_\_\_\_\_  
or by \_\_\_\_\_ Student Embalmer No. \_\_\_\_\_  
working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed Mal Ahon

Licensed Embalmer No. 407

P. O. Address Spring

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.