

U.S. DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS NOV 30 1959

59-042406

STATE FILE NUMBER

Registration District No. _____ Primary Registration District No. _____ Registrar's No. **210681**

1. PLACE OF DEATH a. COUNTY				2. USUAL RESIDENCE (Where deceased lived: If institution: Residence before admission) a. STATE Missouri b. COUNTY			
b. CITY (if outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis		Length of stay in 1b		c. CITY OR TOWN St. Louis		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Homer G. Phillips			Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 1153 1/2 N. Euclid		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Junior Middle Richardson Last			4. DATE OF DEATH Month 11 Day 17 Year 59				
5. SEX Male	6. COLOR OR RACE Negro	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 1 Mar 1891	9. AGE (last birthday) 68	IF UNDER 1 YEAR Months	IF UNDER 24 HR Days	Hours
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY unemployed		11. BIRTHPLACE (City and state or country) Arkansas		12. CITIZEN OF WHAT COUNTRY USA	
13a. FATHER'S NAME ? ?		13b. MOTHER'S MAIDEN NAME ? ?		14. NAME OF HUSBAND OR WIFE - -			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. unknown		17. INFORMANT Address Mrs. Elmer Jones - 1153 1/2 N. Euclid			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Thrombosis						INTERVAL BETWEEN ONSET AND DEATH Undet.	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.						DUE TO (b) Hypertensive Cardiovascular Disease, Arteriosclerotic Heart Disease with Fibrillations Undet.	
DUE TO (c) H20.0							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Metastatic Malignancy on Nine Dorsal Vertebrae						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	
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		COUNTY	STATE
21. I attended the deceased from 11-2-59 to 11-17-59 and last saw <input checked="" type="checkbox"/> him alive on 11-17-59		Death occurred at 12:50 a.m. on the date stated above, and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE (Degree or title) <i>Sydney A. Traver</i>			22b. ADDRESS 2601 N. Whittier St.			22c. DATE SIGNED 11-17-59	
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal		23b. DATE 11-23-59	23c. NAME OF CEMETERY OR CREMATORY Washington Park Cemetery		23d. LOCATION (City, town, or county) (State) Berkeley Mo.		
24. FUNERAL DIRECTOR Atkins Bros.			ADDRESS 3644 Finney		25. DATE RECD. BY LOCAL REG. NOV 19 1959		26. REGISTRAR'S SIGNATURE <i>Earl Smith, M.D.</i> <i>mjb</i>

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

6091 2 DEC 59 SA

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 John R. Cunningham

Licensed Embalmer No. 476

P. O. Address 4700 Hammon

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.