

JR: DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

=60-002484

FILED VS FEB 10 1960

Registration District No. 206 Primary Registration District No. 4317 Registrar's No. 7

STATE FILE NUMBER

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|--|--|--|--|
| 1. PLACE OF DEATH a. COUNTY <u>MADISON</u> | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MO</u> b. COUNTY <u>MADISON</u> | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>MARQUAND</u> | | Length of stay in 1b | c. CITY OR TOWN <u>MARQUAND</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION | | Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> | d. STREET ADDRESS (If outside, give location) Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> |

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|--|---------------------------|---|--|---|---|---|
| 3. NAME OF DECEASED (Type of print) First Middle Last <u>WILLIAM SIDNEY RICHARDS</u> | | | 4. DATE OF DEATH Month Day Year <u>1 31 1960</u> | | | |
| 5. SEX <u>M</u> | 6. COLOR OR RACE <u>W</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>9/19-1880</u> | 9. AGE (last birthday) <u>79</u> | IF UNDER 1 YEAR Months Days Hours Min. | IF UNDER 24 HR |
| 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>ROTI-RAD</u> | | 11. BIRTHPLACE (City and state or country) <u>MADISON MO</u> | | 12. CITIZEN OF WHAT COUNTRY <u>USA</u> |
| 13a. FATHER'S NAME <u>MILLS RICHARDS</u> | | 13b. MOTHER'S MAIDEN NAME <u>NANCY PRIDAY</u> | | 13c. NAME OF HUSBAND OR WIFE <u>REBECCA RICHARDS</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. | | 17. INFORMANT <u>GLADYS HOUIS. MARQUAND MO</u> Address | | |

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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: | | INTERVAL BETWEEN ONSET AND DEATH |
| IMMEDIATE CAUSE (a) <u>(1) Congestive heart failure</u> | | |
| DUPLICATE (b) <u>(2) Terminal Uremia</u> | | |
| DUPLICATE (c) <u>(3) Atherosclerosis (generalized)</u> | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) | | 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 Month, Day, Year a.m. p.m. | | | |

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|--|--|------------------------------|--------|-------|
| 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 <u>11-3-59</u> to <u>12-5-59</u> and last saw him alive on <u>12-5-59</u> . Death occurred at <u>5 P.M. 1-31-60</u> m on the date stated above, and to the best of my knowledge, from the causes stated. | | | | |

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|---|----------------------------|--|---|-----------------------------------|
| 22a. SIGNATURE (Degree or title) <u>Walter M Ester MD.</u> | | 22b. ADDRESS <u>Cape Gir. Mo 714 Broadway</u> | | 22c. DATE SIGNED <u>2-1-60</u> |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | 23b. DATE <u>2/2/60</u> | 23c. NAME OF CEMETERY OR CREMATORY <u>MOOREGHTER PARK COM</u> | 23d. LOCATION (City, town or county) (State) <u>MADISON MO</u> | |
| 24. FUNERAL DIRECTOR <u>Edw. M. Marquand</u> | ADDRESS <u>910</u> | 25. DATE RECD. BY LOCAL REG. <u>2-6-1960</u> | 26. REGISTRAR'S SIGNATURE <u>Flora Lee Hicks</u> | |

(Licensed Embalmer's Statement on Reverse Side)

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

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

Raymond B. Wilson

Licensed Embalmer No. 4884

P. O. Address Fredonia

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to conform 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.