

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

-60-042746  
STATE FILE NUMBER

**FILED VS NOV 22 1960**

Registration District No. 187 Primary Registration District No. 3040 Registrar's No. 218

1. PLACE OF DEATH a. COUNTY <u>Livingston</u>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Caldwell</u>		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Chillicothe</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>Braymer, RFD</u>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Chillicothe Hosp.</u>		Length of stay in lb <u>2 days</u>	d. STREET ADDRESS <u>301</u> (If outside, give location)		Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last <u>OTTO HARRY RICHARDSON</u>			4. DATE OF DEATH Month Day Year <u>Nov. 12, 1960</u>		
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</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>Nov. 8, 1887</u>	9. AGE (In years by birthday) <u>72 yrb.</u>	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) <u>farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own farm</u>	11. BIRTHPLACE (City and state or country) <u>Missouri</u>	12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13a. FATHER'S NAME <u>John T. Richardson</u>		13b. MOTHER'S MAIDEN NAME <u>I sabelle Mobray</u>		14. NAME OF HUSBAND OR WIFE <u>Flora Richardson,</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. <u>498-40-5589</u>	17. INFORMANT Address <u>Flora Richardson, Braymer, Mo. R0D</u>		
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>Cerebral Hemorrhage</u>					INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) <u>331X</u>					
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 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 <u>Nov. 10-60</u> , to <u>Nov. 12-60</u> and last saw <sup>her</sup> alive on <u>Nov. 12-60</u> Death occurred at <u>9:30/A</u> m on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE (Degree or title) <u>Joseph A. Conrad MD</u>			22b. ADDRESS <u>Chillicothe, Mo</u>		22c. DATE SIGNED <u>11-14-60</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>11-15-60</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Plymouth Cem.</u>		23d. LOCATION (City, town, or county) (State) <u>Braymer, Mo</u>
24. FUNERAL DIRECTOR ADDRESS <u>Mead*Pitts Funeral Service, Braymer, Mo.</u>			25. DATE RECD. BY LOCAL REG. <u>Nov 14, 1960</u>	26. REGISTRAR'S SIGNATURE <u>Annalee Taylor</u>	

pt. Health, & Welfare S. Public Health Service

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securing the medical certification in the specific manner required by 193.140 MO.RS. 1949. Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. 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 *John W. Pitts* .....

Licensed Embalmer No. *5074* .....

P. O. Address *Braymer, 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.