SSOURI DIVISION OF HEALTH – STANDARD CERTIFICATE OF DEATH

-61-012832
STATE FILE NUMBER

AMENDED

Registration District No. 43. Primary Registration District No. 3007. Registrar's No. 14.

FILED MAY 1 1961

DATE AMENDED

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

BY AFFIDAVIT OF

MEDICAL CERTIFICATION

1. PLACE OF DEATH
a. COUNTY: Butler
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN: Poplar Bluff — Length of stay in 1b:
c. FULL NAME OF HOSPITAL OR INSTITUTION (If NOT in hospital, give location): Doctor's Hospital — Inside Limits: Yes ☒ No ☐

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Arkansas b. COUNTY: Clay
c. CITY OR TOWN: Corning — Inside Limits: Yes ☒ No ☐
d. STREET ADDRESS (If outside, give location): 514 W. 2nd. — Reside on Farm: Yes ☐ No ☒

3. NAME OF DECEASED (Type or print): First: DR. M. C. Middle: Last: RICHARDSON
4. DATE OF DEATH: Month: March Day: 24, Year: 1961

5. SEX: Male
6. COLOR OR RACE: White
7. Married ☒ Never Married ☐ Widowed ☐ Divorced ☐
8. DATE OF BIRTH: 8-30-1885
9. AGE (last birthday): 75 — IF UNDER 1 YEAR: Months 6 Days 26 — IF UNDER 24 HR: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Doctor M.D.
10b. KIND OF BUSINESS OR INDUSTRY: Medicine
11. BIRTHPLACE (City and state or country): Smithville, Ark.
12. CITIZEN OF WHAT COUNTRY: USA

13a. FATHER'S NAME:
13b. MOTHER'S MAIDEN NAME:
14. NAME OF HUSBAND OR WIFE: Ella N. Richardson

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service): -------
16. SOCIAL SECURITY NO.: None
17. INFORMANT: Pat Richardson Address: Temple, Texas

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Encephalomalacia
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b): Cerebral arteriosclerosis
DUE TO (c): Generalized arteriosclerosis
INTERVAL BETWEEN ONSET AND DEATH:

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a): Diabetes mellitus

PART III. If deceased was female was there a pregnancy in last 90 days. ☐ Yes ☐ No ☐ Unknown

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐
20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐
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 ☐ NOT WHILE AT WORK ☐
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 3-11-61, to 3-24-61 and last saw her/him alive on 3-24-61
Death occurred at 11:30 A M m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title): David V. Mueller M.D.
22b. ADDRESS: 621 Pine-Poplar Bluff, Mo.
22c. DATE SIGNED: 4-24-61

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE: 3-26-61
23c. NAME OF CEMETERY OR CREMATORY: Corning Cemetery
23d. LOCATION (City, town, or county) (State): Corning, Arkansas

24. FUNERAL DIRECTOR: Russell -Ermert ADDRESS: Box 377 Corning, Ark.
25. DATE RECD. BY LOCAL REG.: 4-26-61
26. REGISTRAR'S SIGNATURE: Thelma Graham

(Licensed Embalmer's Statement on Reverse Side)

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 Leslie A. Russell

Licensed Embalmer No. 3855

P. O. Address Corning, Ar

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.