

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

**-62-004407**

STATE FILE NUMBER

Registration District No. **318**

Primary Registration District No. **1003**

Registrar's No. **1169**

**FILED FEB 2 1962**

AMENDED

1. PLACE OF DEATH a. COUNTY				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)			
b. CITY (if outside corporate limits, give TOWNSHIP only) OR TOWN <b>ST. LOUIS, MISSOURI</b>				Length of stay in 1b <b>8 Days</b>		c. CITY OR TOWN <b>FENTON</b>	
c. FULL NAME OF (If not in final location, give location) HOSPITAL OR INSTITUTION <b>BARNES HOSPITAL</b>				Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS <b>709 GRAYOIS BL</b>	
3. NAME OF DECEASED (Type or print)				First Middle Last		4. DATE OF DEATH Month Day Year	
<b>LORENE L. RICHARDT</b>						<b>JANUARY 21, 1962</b>	
5. SEX <b>FEMALE</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>AUG 19-1920</b>	9. AGE (last birthday) <b>41</b>	IF UNDER 1 YEAR Months Days	IF UNDER 24 HR Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSE WIFE</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>HOME</b>	11. BIRTHPLACE (City and state or country) <b>JEFFERSON CITY Mo.</b>		12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>		
13a. FATHER'S NAME <b>CHRIST RINNE</b>			13b. MOTHER'S MAIDEN NAME <b>MALINDA RICHEY</b>			14. NAME OF HUSBAND OR WIFE <b>EMIL RICHARDT</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>NONE</b>		17. INFORMANT <b>EMIL RICHARDT</b> Address <b>709 GRAYOIS BL FENTON Mo.</b>		
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) <b>CEREBRAL HEMORRHAGE</b>						<b>9 DAYS</b>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.						DUE TO (b) <b>HYPERTENSION</b>	
						DUE TO (c) <b>331X</b>	
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 checked="" type="checkbox"/> No <input type="checkbox"/> Unknown	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input 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.		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 <b>JANUARY 15, 1962</b> to <b>JAN. 24, 1962</b> and last saw her alive on <b>JANUARY 24, 1962</b> Death occurred at <b>3:10 A.M.</b> m on the date stated above, and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE (Degree or title) <b>C. D. Vermillion, M.D.</b>				22b. ADDRESS <b>BARNES HOSPITAL</b>		22c. DATE SIGNED <b>1/24/62</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>REMOVAL</b>		23b. DATE <b>JAN-27-1962</b>	23c. NAME OF CEMETERY OR CREMATORY <b>PARK HILL Cem</b>		23d. LOCATION (City, town, or county) (State) <b>SAPPINGTON Mo</b>		
24. FUNERAL DIRECTOR <b>FEV FUNERAL HOME MENVILLE Mo</b>				25. DATE RECD. BY LOCAL REG. <b>JAN 26 1962</b>		26. REGISTRAR'S SIGNATURE <b>Loan Smith, M.D.</b>	

DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS  
INSTEAD OF

ITEM NO. SHOULD READ

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 me,  
or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_  
working under my personal supervision.

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

Signed Herbert J. Dan Jr.

Licensed Embalmer No. 4800

P. O. Address Kirkwood 27

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.