

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-62-004408

AMENDED

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 764

STATE FILE NUMBER

FILED JAN 25 1962

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 <u>St. Louis, Mo.</u>		a. STATE <u>Mo.</u>	b. COUNTY <u>St. Louis</u>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>St. Louis State Hospital</u>		c. CITY OR TOWN <u>St. Louis County</u>	Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <u>8748 Susan</u>	Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print)	First	Middle	Last	4. DATE OF DEATH	Month	Day	Year
	<u>GEORGE</u>	<u>V.</u>	<u>RICHMOND</u>		<u>Jan.</u>	<u>16th,</u>	<u>1962</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>12-8-97</u>	9. AGE (last birthday) <u>64 yrs.</u>	IF UNDER 1 YEAR Months	IF UNDER 24 HR Days	Hours	Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Manufacturing Co.</u>	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) <u>Kenton, Ohio</u>	12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>
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13a. FATHER'S NAME <u>George Richmond, Sr.</u>	13b. MOTHER'S MAIDEN NAME <u>Minnie (Castile)</u>	14. NAME OF HUSBAND OR WIFE <u>Mary R. Richmond</u>
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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>Mary R. Richmond 8748 Susan St. Louis Co.</u>	Address <u>Mo.</u>
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18. CAUSE OF DEATH (Enter only one cause per line for PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bronchopneumonia</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>491x</u> DUE TO (c)	INTERVAL BETWEEN ONSET AND DEATH <u>approx 10d</u>
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PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Chronic liver syndrome due to metabolic disturbance</u>	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"/>	20b. SUICIDE <input type="checkbox"/>	20c. HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)
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20c. TIME OF INJURY Hour s.m. p.m.	Month, Day, Year
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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
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21. attended the deceased from Sept. 22, 1960 to Jan. 16, 1962 and last saw him alive on Jan. 16, 1962

Death occurred at George E. Smith, M.D. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <u>George E. Smith M.D.</u>	22b. ADDRESS <u>5400 Arsenal St.</u>	22c. DATE SIGNED <u>1-16-62</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>1-19-62</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Laurel Hill Gardens Cem.</u>	23d. LOCATION (City, town, or county) <u>St. Louis County</u>	(State)
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24. FUNERAL DIRECTOR <u>Alexander & Sons, 6175 Delmar Blvd.</u>	ADDRESS	25. DATE RECD. BY LOCAL REG. <u>JAN 17 1962</u>	26. REGISTRAR'S SIGNATURE <u>Carl Smith, M.D.</u>
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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

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 J. Allen Daniels

Licensed Embalmer No. 4053

P. O. Address Jan 16-1962

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.