

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

=62-028361

STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. 316 Primary Registration District No. 3059 Registrar's No. 304

VS 300
Rev. 4/59

1 0941
2 0941
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4 1
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12 90-0
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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

ITEM NO. SHOULD READ

USE BLACK INK OR TYPEWRITER RIBBON

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

FILED JUL 24 1962		1. PLACE OF DEATH		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)	
a. COUNTY <u>St Francois</u>		b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Bonne Terre</u>		a. STATE <u>Mo</u> b. COUNTY <u>St Francois</u>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>422 Ash St</u>		Length of stay in lb <u>36 yrs</u>		c. CITY OR TOWN <u>Bonne Terre</u> Inside Limits <input checked="" type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Mary</u> Middle <u>Josephine</u> Last <u>Richeson</u>		d. STREET ADDRESS (If outside, give location) <u>422 Ash St</u>		d. STREET ADDRESS (If outside, give location) <u>422 Ash St</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
4. DATE OF DEATH Month <u>July</u> Day <u>15</u> Year <u>1962</u>		5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>	
7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <u>5-22-1872</u>		9. AGE (last birthday) <u>90</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life even if retired) <u>housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>		11. BIRTHPLACE (City and state or country) <u>Washington County Mo. US</u>	
13a. FATHER'S NAME <u>Michael Geier</u>		13b. MOTHER'S MAIDEN NAME <u>Susan Allen</u>		14. NAME OF HUSBAND OR WIFE <u>Albert E. Richeson (dec)</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>None</u>		17. INFORMANT <u>Mrs Clifford Wigger, Bonne Terre, Mo</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>11 days</u>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.		DUE TO (b) <u>Hypertensive Vascular Disease - 14 years</u>			
DUE TO (c)					
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 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 <u>4:00</u> a.m. p.m.		Month, Day, Year <u>May 1948</u>			
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>May 1948</u> to <u>July 11, 1962</u> and last saw her alive on <u>July 11, 1962</u>		Death occurred at <u>4:00</u> <u>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>Marvin J. Haw, Jr. M.D.</u>		22b. ADDRESS <u>Bonne Terre Mo.</u>		22c. DATE SIGNED <u>7/17/62</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>Jul 17, 1962</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Masonic Cemetery</u>	
24. FUNERAL DIRECTOR <u>C.Z. Boyer & Son, Inc. Bonne Terre, Mo</u>		25. DATE RECD. BY LOCAL REG. <u>July 17, 1962</u>		26. REGISTRAR'S SIGNATURE <u>Ether Rudloff</u>	

(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 Burlin T. Boyer

Licensed Embalmer No. 5117

P. O. Address Bonne Terre, 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.