

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-62-016421

STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. 297 Primary Registration District No. 6.022 Registrar's No. 40

FILED APR 24 1962

VS 300  
Rev. 4/59

1	0890
2	1890
3	2
4	1
5	0
6	
7	0
8	2
9	7545
10	
11	
12	1-0
13	2-0

DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

ITEM NO. SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

USE BLACK INK OR TYPEWRITER RIBBON

1. PLACE OF DEATH a. COUNTY <u>Ray</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Ray</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Richmond township</u>		c. CITY OR TOWN <u>Orrick</u>	
Length of stay in 1b <u>5 hours</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Ray County Memorial Hosp.</u>		d. STREET ADDRESS (If outside, give location) <u>No street address</u>	
Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>KIMBERLY ANN RICHARDSON</u>			4. DATE OF DEATH Month Day Year <u>April 17, 1962</u>
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>4/17/1962</u>
9. AGE (last birthday) Months Days Hours Mins. <u>5 0 0 0</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>	11. BIRTHPLACE (City and state or country) <u>Richmond, Mo.</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>	12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>
13a. FATHER'S NAME <u>Dale Gene Richardson</u>		13b. MOTHER'S MAIDEN NAME <u>Beula Frances Barrrt</u>	14. NAME OF HUSBAND OR WIFE <u>Never married</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 Address <u>Dale G. Richardson, Orrick, 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>Heart dis congenital</u> Mongolian Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____			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)			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
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 Month, Day, Year s.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 <u>birth</u> to <u>death</u> and last saw her <u>him</u> alive on <u>4-17</u> . Death occurred at <u>7:45 a.</u> m on the date stated above, and to the best of my knowledge the causes stated.			
22a. SIGNATURE <u>[Signature]</u> (Degree or title)		22b. ADDRESS <u>[Signature]</u>	22c. DATE SIGNED <u>4-17-62</u> (State)
23a. BURIAL, CREMATION OR REMOVAL (Specify) <u>Removal</u>	23b. DATE <u>4/17/1962</u>	23c. NAME OF CEMETERY OR CREMATORY <u>South Point Cemetery</u>	23d. LOCATION (City, town, or county) <u>Orrick, Mo.</u>
24. FUNERAL DIRECTOR ADDRESS <u>McAfee Funeral Home, Orrick, Mo.</u>		25. DATE RECD. BY LOCAL REG. <u>4-19-1962</u>	26. REGISTRAR'S SIGNATURE <u>Malcol Jackson</u>

**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 Charles F. Tyler  
Licensed Embalmer No. 4534

P. O. Address Liberty 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.

*not embalmed*