MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

Do not use this space.

18239

1. PLACE OF DEATH
County: St. Francois
Township: St. Francois
City: Near Farmington (No. ..... St. ..... Ward)

Registration District No. 773
Primary Registration District No. 6018 A

File No. .....
Registered No. 77

2. FULL NAME: Annie Bell Richardson
(a) Residence. No. Hospital No. 4- St., ... Ward. Belleview, Mo
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred 23 yrs. 8 mos. 29 ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (*write* the word): Married

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF: James Richardson

6. DATE OF BIRTH (MONTH, DAY AND YEAR): Not known

7. AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
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8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer): .....
(c) Name of employer: .....

9. BIRTHPLACE (CITY OR TOWN): Belleview
(STATE OR COUNTRY): Missouri

PARENTS

10. NAME OF FATHER: Not known
11. BIRTHPLACE OF FATHER (CITY OR TOWN): Unknown
(STATE OR COUNTRY): Unknown
12. MAIDEN NAME OF MOTHER: Unknown
13. BIRTHPLACE OF MOTHER (CITY OR TOWN): Unknown
(STATE OR COUNTRY): Unknown

14. INFORMANT: Commitment Papers
(Address)

15. FILED: 5-22, 1928 B. J. Robinson, REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR): May 19 1928

17. I HEREBY CERTIFY, That I attended deceased from Jan 16, 1928, to May 19, 1928, that I last saw b. or alive on May 19, 1928, and that death occurred, on the date stated above, at 11 o'clock P.M.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Cancer Uterus
(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (SECONDARY) .....
(duration) ..... yrs. ..... mos. ..... ds.

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH? .....
DID AN OPERATION PRECEDE DEATH? No. DATE OF .....
WAS THERE AN AUTOPSY? No
WHAT TEST CONFIRMED DIAGNOSIS? Lab.
(Signed) Chas. P. Brown, M. D
5-21, 1928 (Address) State Hospital No. 4,

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL: Hospital Cemetery
DATE OF BURIAL: May 21 1928
20. UNDERTAKER: Hospital No 4
ADDRESS: Farmington Mo

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

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