

24074

State File No. _____

6347

Registrar's No. _____

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

REC'D AUG 11 1939
Registration District No. 119

791
1003

Primary Registration District No. _____

1. PLACE OF DEATH:

(a) County _____
(b) City or town St. Louis
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Homer Phillips Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution Since July 3, 1939
(Specify whether _____)
In this community 30 years
years, months or days

3. (a) PRINT FULL NAME Iseac Richardson 263

3. (b) If veteran, name war no 3. (c) Social Security No. nil

4. Sex M 5. Color or race C 6. (a) Single, widowed, married, divorced Widowed

6. (b) Name of husband or wife Unknown (deceased) 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased January 1, 1874
(Month) (Day) (Year)

8. AGE: Years 65 Months 6 Days 14 If less than one day _____ hr. _____ min.

9. Birthplace Louisiana
(City, town, or county) (State or foreign country)

10. Usual occupation nil

11. Industry or business _____

12. Name unknown

13. Birthplace unknown
(City, town, or county) (State or foreign country)

14. Maiden name unknown

15. Birthplace unknown
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature Mable Holley

(b) Address 4216 E N Market

17. (a) Burial (b) Date thereof 7/19/39
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation E. St. Louis, Ill

18. (a) Signature of funeral director [Signature]

(b) Address 3517 Lechade Ave

19. (a) JUL 18 1939 (b) _____
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County _____
(c) City or town St. Louis
(If outside city or town limits, write "RURAL")
(d) Street No. 4216 E N Market
(If rural, give location)
(e) If foreign born, how long in U. S. A. _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 15
year 1939 hour 4 minute 40 A. M.

21. I hereby certify that I attended the deceased from July 3, 1939
_____ 19____ to July 15, 1939 19____
that I last saw him alive on July 15, 1939 19____
and that death occurred on the date and hour stated above.

Immediate cause of death Arteriosclerotic heart disease Duration 8-10 yrs

Due to _____

Due to _____

Other conditions Chronic nephritis unknown
(include pregnancy within 3 months of death)

Major findings: Of operations _____

Of autopsy _____

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify) _____

(b) Date of occurrence _____

(c) Where did injury occur? _____
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place?
_____ (Specify type of place)

While at work? _____ (e) Means of injury _____
28. Signature [Signature] (M. D. or other) _____
Address 2601 N. Whittier Date signed 7/17/39

WHILE FILLING IN USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

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.

1 1939

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.....

....., Registered Apprentice No.....

working under my personal supervision.

Signed

P. M. Green

Licensed Embalmer No.

1173

P.O. Address

3517 Saddle Creek Ave

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 this body is not embalmed, above space should be left blank.