

SEP 6 1939

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

28331
Do not use this space.

1. PLACE OF DEATH

(a) County Jackson Registration District No. 379
(b) Township Kaw Primary Registration District No. 1002
(c) City Kansas City, Mo. (d) Street No. 127 N. Wheeling St.
(If death occurred in Hospital or Institution, write its name instead of street and number)
(e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U.S., if of foreign birth? yrs. mos. ds.

Registered No. 3333

2. PRINT FULL NAME William Richardson

(a) Residence, No. 127 N. Wheeling St.
(Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M	4. COLOR OR RACE W	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Married
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Emma A. Richardson		
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Nov. 16, 1859		
7. AGE YEARS 79	MONTHS 9	DAYS 5
If LESS than 1 day,hrs. ormin.		
OCCUPATION	8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Retired P.O. Clerk	
	9. Industry or business in which work was done, as saw mill, bank, etc.	
	10. Date deceased last worked at this occupation (month and year).....	
		11. Total time (years) spent in this occupation.....

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) **Aug. 21, 1939**
22. I HEREBY CERTIFY, That I attended deceased from **June 1**, 19**39**, to **Aug 21**, 19**39**
I last saw him alive on **Aug 21**, 19**39** Death is said to have occurred on the date stated above, at **2:30** m. PM
The principal cause of death and related causes of importance were as follows:

Arterio Sclerosis

Date of onset
8/21

Other contributory causes of importance:

Hypertension & Heart

Name of operation..... Date of.....
What test confirmed diagnosis? **Syncope** Was there an autopsy? **no**

23. If death was due to external causes (violence), fill in also the following:
Accident, suicide, or homicide?..... Date of injury....., 19.....
Where did injury occur?..... (Specify city or town, county, and State)
Specify whether injury occurred in industry, in home, or in public place.

Manner of injury.....
Nature of injury.....

24. Was disease or injury in any way related to occupation of deceased? **no**
If so, specify.....
(Signed) **R L B. Bauer**, M. D.
(Address) **5242 S. John**

FATHER	12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Illinois
	13. NAME James F. Richardson
MOTHER	14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Tenn.
	15. MAIDEN NAME Elizabeth Southard
	16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Unknown

17. INFORMANT Mrs. Emma A. Richardson
(ADDRESS) 127 N. Wheeling, K.C. Mo.
18. BURIAL, CREMATION, OR REMOVAL PLACE Brookings Cem. DATE Aug. 21-39
19. FUNERAL DIRECTOR (NAME) C.H. Blackman & Son, Inc.
(ADDRESS) 2825 Indep. Blvd. K.C. Mo.
20. FILED 8/23 1939 M. M. Crowe
Local Registrar.

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.

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..... *W D Blackman*
Licensed Embalmer No. *3639*
P. O. Address..... *K. C. 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 this body is not embalmed, above space should be left blank.