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.

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
JAN 12 1940

MISSOURI STATE BOARD OF HEALTH

# STANDARD CERTIFICATE OF DEATH

State File No. 41405

Registration District No. 701 Primary Registration District No. Registrar's No. 10528

**1. PLACE OF DEATH:** 1003 2

(a) County St Louis Mo

(b) City or town (If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: 4053 Parker (If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution (Specify whether In this community 10 Years years, months or days)

**2. USUAL RESIDENCE OF DECEASED:** 1

(a) State Missouri (b) County

(c) City or town St. Louis 16 (If outside city or town limits, write "RURAL")

(d) Street No. 4053 Parker (If rural, give location)

(e) If foreign born, how long in U. S. A.? years.

3. (a) PRINT FULL NAME Amanda M. Richardson 213

3. (b) If veteran, name war No

3. (c) Social Security No. No

4. Sex F

5. Color or race White

6. (a) Single, widowed, married, divorced Widowed

6. (b) Name of husband or wife John

6. (c) Age of husband or wife if alive years

7. Birth date of deceased Nov 17 (Month) 1851 (Day) (Year)

8. AGE: Years 88 Months 0 Days 21 If less than one day hr. min.

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

10. Usual occupation Housewife

11. Industry or business

FATHER
12. Name Unknown
13. Birthplace Unknown (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name Unknown
15. Birthplace Unknown (City, town, or county) (State or foreign country)

16. (a) Informant's own signature [signature]
(b) Address 4053 Parker Ave.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/9/39 (Month) (Day) (Year)
(c) Place: burial or cremation St. Matthew's Cemetery

18. (a) Signature of funeral director Oscar J. Hoffmeister
(b) Address 4016 Chippewa St.

19. (a) [illegible] 3 1939 (Date received local registrar) (b) [signature] (Registrar's signature)

**MEDICAL CERTIFICATION**

20. DATE OF DEATH: Month Dec. day 8 year 1939 hour 9 minute 20 a. M.

21. I hereby certify that I attended the deceased from , 19 , to , 19 ; that I last saw her alive on 12/6/39 , 19 ; and that death occurred on the date and hour stated above.

| | Duration |
|---|---|
| Immediate cause of death Auricular Fibrillation | 6 mos |
| Due to Myocardial Failure Senility | 3 yrs |
| Due to Gangrene of Foot | 3 wks |
| Other conditions Heart Block [illegible] (Include pregnancy within 3 months of death) | 3 mos. |

Major findings: Of operations None

Of autopsy None

PHYSICIAN — Underline the cause to which death should be charged statistically

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

23. Signature Walter H. Hoyer (M. D. or other) MD
Address 2602 S. Grand Date signed 12/8/39

(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.....

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

working under my personal supervision.

Signed Ernest W. Spillars

Licensed Embalmer No. 14080

P. O. Address 3528 Russell Pl.

**Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply wi the above constitutes grounds for revocation of license.)**

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