

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. _____

Registrar's No. _____

JUN 15 1940
Registration District No. 678

Primary Registration District No. 5904

81

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH:

(a) County Bellevue Co
(b) City or town St Joseph Mo
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: St Joseph Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____
(Specify whether years, months or days) _____

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Bellevue
(c) City or town St James, Mo.
(If outside city or town limits, write "RURAL")
(d) Street No. Federal Soldiers Home
(If rural, give location)
(e) If foreign born, how long in U. S. A? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 22-40
year 1940 hour 5:30 P.M. minute _____ M.
21. I hereby certify that I attended the deceased from May 18th
_____ 1940, to May 22, 1940
that I last saw him alive on May 22, 1940;
and that death occurred on the date and hour stated above.

Immediate cause of death Impact of
Bomb

Due to Death Cancer of
Rizoid portion of Prostate
Due to _____

Other conditions _____
(Include pregnancy within 3 months of death) 46

Major findings:
Of operations None
Of autopsy None

Duration _____
PHYSICIAN _____
Underline the cause to which death should be charged statistically.

3. (a) PRINT FULL NAME Willa Richter 236

3. (b) If veteran, name war _____ 3. (c) Social Security No. None

4. Sex Female 5. Color or race white 6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband Carl C. Richter 6. (c) Age of husband or wife if alive 65 years
7. Birth date of deceased May 3 1884
(Month) (Day) (Year)

8. AGE: Years 56 Months 0 Days 19 If less than one day hr. _____ min. _____

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

10. Usual occupation Housewife

11. Industry or business _____

12. Name _____

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

14. Maiden name _____

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

16. (a) Informant A. B. Bullard
(b) Address _____

17. (a) _____ (b) Date thereof _____
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Marquette Term

18. (a) Signature of funeral director W. H. Miller

(b) Address W. H. Miller, St. Joseph

19. (a) 6-5-40 (b) Blair B. Beach
(Date received local registrar) (Registrar's signature)

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? 611
(Specify type of place) (e) Means of injury _____

23. Signature W. H. Miller (M. D. or other) _____
Address St. Joseph Mo Date signed 6-4-40

SEP 29 1947

Handwritten notes and signatures, including the name "James" and "James C. ..."

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.

RECEIVED

District Health Officer No. 5,

District File Number. 640 692

Date Filed 6/24/40

Signed *Orville E. Licklider*

Licensed Embalmer No. 3546

P. O. Address *St James*

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.