

No. 2  
-13-40  
-17-39  
X23159

Registration District No. **449** Primary Registration District No. **5613** Registrar's No. \_\_\_\_\_

53  
0  
0  
WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH:  
(a) County **Laclede**  
(b) City or town **Rural Springfield Two**  
(c) Name of hospital or institution:  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution **1** (Specify whether  
In this community \_\_\_\_\_ years, months or days)

2. USUAL RESIDENCE OF DECEASED:  
(a) State **Mo** (b) County **Laclede**  
(c) City or town **Rural**  
(d) Street No. **0**  
(e) If foreign born, how long in U. S. A? \_\_\_\_\_ years.

3. (a) PRINT FULL NAME **Jay Richardson**  
3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. **none**

MEDICAL CERTIFICATION  
20. DATE OF DEATH: Month **March** day **14**  
year **1941** hour **3** minute **10** M.  
21. I hereby certify that I attended the deceased from \_\_\_\_\_, 19\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_;  
that I last saw him alive on **3-14**, 19**41**;  
and that death occurred on the date and hour stated above.

4. Sex **M** 5. Color or race **W** 6. (a) Single, widowed, married, divorced **Married**  
6. (b) Name of husband or wife **Jay Richardson** 6. (c) Age of husband or wife if alive **26** years  
7. Birth date of deceased **April 18 1916**

Immediate cause of death **Pulmonary Tuberculosis**  
Due to \_\_\_\_\_  
Due to \_\_\_\_\_  
Other conditions **12/11**  
(Include pregnancy within 3 months of death)

8. AGE: Years **24** Months **10** Days **26** If less than one day hr. \_\_\_\_\_ min. \_\_\_\_\_

9. Birthplace **Laclede Co Mo**  
10. Usual occupation **Housewife**  
11. Industry or business \_\_\_\_\_

PHYSICIAN  
Major findings: \_\_\_\_\_  
Of operations \_\_\_\_\_  
Of autopsy \_\_\_\_\_  
Underline the cause to which death should be charged statistically.

MOTHER FATHER { 12. Name **Jay Stevens**  
13. Birthplace **Condens Co Mo**  
14. Maiden name **Media Kirkwood**  
15. Birthplace **Laclede Co Mo**

16. (a) Informant **Jay Richardson**  
(b) Address **Libanon Mo**  
17. (a) **Burial** (b) Date thereof **3/16/41**  
(c) Place: burial or cremation **Balles Cemetery**

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? \_\_\_\_\_  
(d) Did injury occur in or about home, on farm, in industrial place, in public place? \_\_\_\_\_

18. (a) Signature of funeral director **W.E. Holman**  
(b) Address **Libanon Mo**  
19. (a) **3-17-41** (b) **J.M. Lamb**

23. Signature **Paula Jenkins**  
Address **Libanon Mo** Date signed **3/17/41**

RECEIVED  
District Health Officer No. 7  
District File Number 444/201  
Date Filed 4/16/41

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.....  
myself....., Registered Apprentice No.....  
working under my personal supervision.

Signed..... W. E. Holman.....

Licensed Embalmer No. 4107

P. O. Address. Lebanon 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, fact should be so stated above.