

FILED JAN 25 1944

Registration District No. 128

Primary Registration District No. 2000

Registrar's No. 60

1. PLACE OF DEATH:
(a) County **GREENE**
(b) City or town **Springfield MO.**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
2025 N. NEWTON / AVE
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution.....
(Specify whether
In this community.....
years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State **MO.** (b) County **GREENE** **39**
(c) City or town **SPRINGFIELD**
(If outside city or town limits, write "RURAL")
(d) Street No. **2025 N. NEWTON AVE** **6**
(If rural, give location)
(e) Citizen of foreign country? **No** (Yes or No)
If yes, name country **✓** **0**

3. (a) PRINT FULL NAME **SAMUEL A. RICHARDS**
(b) If veteran, name war **NONE**
(c) Social Security No. **UNK.**

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month **JAN** day **14**
year **1944** hour **6** minute **00** A. M.
21. I hereby certify that I attended the deceased from **Aug 15**
1943 to **JAN 14** **1944**
that I last saw him alive on **JAN-14-** **1944**
and that death occurred on the date and hour stated above.

4. Sex **MALE** 5. Color or race **WHITE**
6. (a) Single, widowed, married, divorced **MARRIED**
6. (b) Name of husband or wife **CHRISTANA C. RICHARDS**
6. (c) Age of husband or wife if alive **71** years
7. Birth date of deceased **Sept. 14 1868**
(Month) (Day) (Year)

Immediate cause of death **CEREBRAL - HEMORRHAGE -**
Duration

8. AGE: Years **75** Months **4** Days **0**
If less than one day hr. min.

Due to **HYPERTENSION**
Due to **Hypertensive - cardiac vascular - renal disease**
Other conditions (Include pregnancy within 3 months of death)

9. Birthplace **GREENE CO. MO.**
(City, town, or county) (State or foreign country)
10. Usual occupation **Retired Stationary Engineer**
11. Industry or business **Frisco R.R. Co.**
12. Name **Holloway P. Richards**
13. Birthplace **UNK. UNKNOWN**
(City, town, or county) (State or foreign country)
14. Maiden name **UNK. UNKNOWN**
15. Birthplace **UNK. UNKNOWN**
(City, town, or county) (State or foreign country)
16. (a) Informant **Christana A. Richards**
(b) Address **SPRINGFIELD MO.**
17. (a) **Survival** (b) Date thereof **1-16-44**
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation **Green Lawn Cem.**
18. (a) Signature of funeral director **J. W. Klingner Co.**
(b) Address **SPRINGFIELD MO.**
19. (a) **1-15-44** (b) **B. W. Z. Handley**
(Date received local registrar) (Registrar's signature)

Major findings:
Of operations **13/a**
Of autopsy **✓**
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?

While at work? (Specify type of place) (e) Means of injury
23. Signature **D. F. Youell** (M.D. or other) **DO**
Address **234 1/2 - E Commercial** Date signed **1/15/44**
Springfield, Mo

FEB 3 1944

NOV 13 1944

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

Roy A. ...

Licensed Embalmer No. *1763*

P. O. Address *Springfield, Mo.*

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

If this body is not embalmed, fact should be so stated above.

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