DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED MAR 21 1947

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

10200

State File No.

Registration District No. 264 Primary Registration District No. 5893 Registrar's No. 23

1. PLACE OF DEATH:
(a) County: Ozark
(b) City or town: Rural- Lick Creek Twp.
(If outside city or town limits, write "RURAL" and name of township)
(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 (Specify whether years, months or days)
In this community: 52 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State: Missouri (b) County: Ozark 77
(c) City or town: Mammoth 0
(If outside city or town limits, write "RURAL")
(d) Street No. 0
(If rural, give location)
(e) Citizen of foreign country? no (Yes or No) 0
If yes, name country

3. (a) PRINT FULL NAME: Mollie Richmond
3. (b) If veteran, name war
3. (c) Social Security No.
4. Sex: Female
5. Color or race: White
6. (a) Single, widowed, married, divorced: married
6. (b) Name of husband or wife: Sam G. Richmond
6. (c) Age of husband or wife if alive: 49 years
7. Birth date of deceased: May (Month) 5 (Day) 1894 (Year)

8. AGE:

Years	Months	Days	If less than one day
52	8	9	hr. min.

9. Birthplace: Pontiac (City, town, or county) Missouri (State or foreign country) 0
10. Usual occupation: Housewife
11. Industry or business:
FATHER
12. Name: Landa Barner
13. Birthplace: (City, town, or county) Tenn. (State or foreign country)
MOTHER
14. Maiden name: Mary Sue White
15. Birthplace: (City, town, or county) Kentucky (State or foreign country)
16. (a) Informant: Sam G. Richmond
(b) Address: Mamoth Missouri
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)
(c) Place: burial or cremation
18. (c) Signature of funeral director: Clinkingbeard Funeral Home
(b) Address: Gainesville, Missouri
19. (a) Mar. 5, 1947 (Date received local registrar) (b) Pamela Trump (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month February day 2 year 1947 hour 8 minute 30 A.M.
21. I hereby certify that I attended the deceased from ..., 19..., to ..., 19...; that I last saw h... alive on ..., 19...; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Coronary Artery Disease	Less than 5 min
Due to: Death due to natural	
Due to: causes	
Other conditions (Include pregnancy within 3 months of death)	
Major findings: Of operations:	
Of autopsy: 94 A	

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) 15
While at work? (e) Means of injury
23. Signature: M. J. Haerman Coroner (M. D. or other) 50
Address: Gainesville, Mo. Date signed 2/5/47

997 (Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Officer No. 6
District File Number 347-337
Date Filed MAR 15 1947

APR 6 1949

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 B Hutchison

Licensed Embalmer No. 3431

P. O. Address Gainesville

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

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. April

Registration District No. 264 Primary Registration District No. 893 Registrar's No. 23

1. PLACE OF DEATH:

(a) County: Ozark

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

(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 (Specify whether years, months or days) In this community

2. USUAL RESIDENCE OF DECEASED:

(a) State (b) County

(c) City or town
(If outside city or town limits, write "RURAL")

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

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3. (a) PRINT FULL NAME: Mollie Richmond

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex: F

5. Color or race: W

6. (a) Single, widowed, married, divorced: m

6. (b) Name of husband or wife

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

7. Birth date of deceased: May (Month) 5 (Day) (Year)

8. AGE: Years 52 Months 8 Days If less than one day hr. min.

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

10. Usual occupation

11. Industry or business

MOTHER FATHER

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

(b) Address

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

(c) Place: burial or cremation

18. (a) Signature of funeral director

(b) Address

19. (a) Feb. 5, 1947 (Date received local registrar) (b) Pamela Trump (Registrar's signature)

Signed April 9, 1947

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb Day 12 year 1947 hour minute M.

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

Immediate cause of death — Duration

Due to

Due to

Other conditions
(Include pregnancy within 3 months of death)

Major findings:
Of operations

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? (Specify type of place)

While at work? (e) Means of injury

23. Signature (M. D. or other)

Address Date signed

SUPPLEMENTARY

10200