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MISSOURI DIVISION OF HEALTH
STANDARD CERTIFICATE OF DEATH
1003

FILED DEC 14 1948
Registration District No. 418

Primary Registration District No.

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

1. PLACE OF DEATH: *St. Louis*

(a) County *St. Louis*

(b) City or town *ST. LOUIS*

(c) Name of hospital or institution: *Barns Hospital*
(If outside city or town limits, write "RURAL" and name of township)

(d) Length of stay: In hospital or institution *8 hrs*
(Specify whether In this community years, months or days)

3. (a) PRINT FULL NAME *Herbert L. Richards*

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex *male* 5. Color or race *white*

6. (a) Single, widowed, married, divorced *single*

6. (b) Name of husband or wife

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

7. Birth date of deceased: *Dec. 19 1931*
(Month) (Day) (Year)

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

16 11 15 hr. min.

9. Birthplace *Washington Co. Mo. (1)*
(City, town, or county) (State or foreign country)

10. Usual occupation *Laborer*

11. Industry or business

MOTHER FATHER { 12. Name *William Richards*

13. Birthplace *Washington Co. Mo*
(City, town, or county) (State or foreign country)

14. Maiden name *Grace Fowler*

15. Birthplace *Washington Co. Mo*
(City, town, or county) (State or foreign country)

16. (a) Informant *William Richards*

(b) Address *Petavi Mo*

17. (a) *Burial* (b) Date thereof *12-7-48*
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation *Petavi, Mo*

18. (a) Signature of funeral director *Mr. Luther Spack*

(b) Address *Petavi Mo*

19. (a) *DEC 6 1948* (b) *J. B. Lester*
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State *Missouri* (b) County *Washington*

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

(d) Street No. *Near Petavi*
N.R. (If rural, give location)

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

If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month *Dec* day *XX5th*,
year *1948* hour *12:01* minute *A.P.M.*

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____;

that I last saw him alive on _____, 19____;

and that death occurred on the date and hour stated above.

Immediate cause of death *Hemorrhagic Gliosis* Duration
of brain

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? _____

While at work? _____ (Specify type of place)

(e) Means of injury _____

23. Signature *Patrick E. Taylor* (M. D. or other) *Dep. Cor*

Address *1300 Clark* Date signed *12-6-48*

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.....

Licensed Embalmer No.....

P. O. Address.....

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.