

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

3240  
1003 State File No.  
0271 Registrar's No.

FILED JAN 26 1952

318

WRITE PLAINLY—USING UNFADEING BLACK INK—MAKE A PERMANENT RECORD

BIRTH NO. _____		REG. DIST. NO. _____		PRIMARY REG. DIST. NO. _____		Registrar's No. _____			
1. PLACE OF DEATH a. COUNTY _____ b. CITY (If outside corporate limits, write RURAL and give town OR TOWN) <u>St. Louis, Mo.</u> c. LENGTH OF STAY (In this place township) <u>2 Days</u> d. FULL NAME OF HOSPITAL OR INSTITUTION <u>BARNES HOSPITAL</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>ILLINOIS</u> b. COUNTY <u>MADISON</u> c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Granite City 8120</u> d. STREET ADDRESS (If rural, give location) <u>1752 Chestnut</u>					
3. NAME OF DECEASED a. (First) <u>Marshall</u> b. (Middle) <u>J.</u> c. (Last) <u>Richards</u>			4. DATE OF DEATH (Month) (Day) (Year) <u>1 9 52</u>						
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>MARRIED</u>		8. DATE OF BIRTH <u>July 8, 1883</u>		9. AGE (In years last birthday) <u>68</u> IF UNDER 1 YEAR: Months <u>5</u> Days <u>1</u> Hours <u>1</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Retired 4 years</u>			11. BIRTHPLACE (State or foreign country) <u>Indiana</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13a. FATHER'S NAME <u>James M. Richards</u>			13b. MOTHER'S MAIDEN NAME <u>Ann Higgins</u>			14. NAME OF HUSBAND OR WIFE <u>Margaret Richards</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>			16. SOCIAL SECURITY NO. <u>unknown</u>		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>Marshall Richards Jr. Madison</u>				
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)  *This does not mean the mode of dying, such as heart failure, asphyxia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Left Cerebellar Abscess</u>  ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____  II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>Diffuse Cortical cerebral atrophy</u>						INTERVAL BETWEEN ONSET AND DEATH	
19a. DATE OF OPERATION <u>1-8-52</u>		19b. MAJOR FINDINGS OF OPERATION <u>Left cerebellar abscess</u>						20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT SUICIDE HOMICIDE (Specify) _____		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) _____		21c. (CITY, TOWN, OR TOWNSHIP) _____ (COUNTY) _____ (STATE) _____					
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) <u>Jan 8 1952 7:45 p.m.</u>		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? <u>391.1</u>					
22. I hereby certify that I attended the deceased from <u>1-7</u> , 19 <u>52</u> , to <u>1-9</u> , 19 <u>52</u> , that I last saw the deceased alive on <u>1-9</u> , 19 <u>52</u> , and that death occurred at <u>7:45 p.m.</u> , from the causes and on the date stated above.									
23a. SIGNATURE (Degree or title) <u>Philip S. Nowman M.D.</u>				23b. ADDRESS <u>BARNES HOSPITAL</u>		23c. DATE SIGNED <u>1-10-52</u>			
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		24b. DATE <u>Jan 10, 1952</u>		24c. NAME OF CEMETERY OR CREMATORY <u>CACHE</u>		24d. LOCATION (City, town, or county) (State) <u>Ullin, Illinois</u>			
DATE REC'D BY LOCAL REG. <u>JAN 10 1952</u>		REGISTRAR'S SIGNATURE <u>John Smith M.D.</u>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Labeay J. H. Madison, Ill</u>					

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**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.....

..... Student Embalmer No. ....

working under my personal supervision.

Student .....  
Student Embalmer

Signed

*John Ketter*

Licensed Embalmer No. 3880

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.**