No. 300
10.48

FILED FEB 7 - 1955

# THE DIVISION OF HEALTH OF MISSOURI
## STANDARD CERTIFICATE OF DEATH

State File No. 3011

BIRTH NO. _____ REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003 Registrar's No. 0874

**1. PLACE OF DEATH**
a. COUNTY
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): St. Louis
c. LENGTH OF STAY (In this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 798 Bayard Ave.,

**2. USUAL RESIDENCE** (Where deceased lived. If institution: residence before admission).
a. STATE: Missouri
b. COUNTY
c. CITY OR TOWN: St. Louis
d. Is Residence within limits of a city or incorporated town? Yes [X] No [ ]
STREET ADDRESS (If rural, give location): 12 798 Bayard Ave., 2129 0

**3. NAME OF DECEASED** (Type or Print)
a. (First): ARTHUR
b. (Middle): E.
c. (Last): RICHARDSON

**4. DATE OF DEATH** (Month) (Day) (Year): Jan. 30, 1955

**5. SEX**: Male 0

**6. COLOR OR RACE**: White

**7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED** (Specify): Married

**8. DATE OF BIRTH**: June 22, 1904

**9. AGE** (In years last birthday): 50 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

**10a. USUAL OCCUPATION** (Give kind of work done during most of working life, even if retired): Painter

**10b. KIND OF BUSINESS OR INDUSTRY**

**11. BIRTHPLACE** (City and State or Foreign Country): Portageville, Mo. 0

**12. CITIZEN OF WHAT COUNTRY?**: us

**13a. FATHER'S NAME**: James Richardson

**13b. MOTHER'S MAIDEN NAME**: Jannie Baley

**14. NAME OF HUSBAND OR WIFE**: Lucile Richardson

**15. WAS DECEASED EVER IN U.S. ARMED FORCES?** (Yes, no, or unknown): No
(If yes, give war or dates of service)

**16. SOCIAL SECURITY NO.**

**17. INFORMANT'S SIGNATURE OR NAME ADDRESS**: Lucile Richardson, 798 Bayard Ave.,

**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, asthenia, etc. It means the disease, injury, or complication which caused death.*

**MEDICAL CERTIFICATION**

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Degenerative heart disease — INTERVAL BETWEEN ONSET AND DEATH: Not known

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.*

**19a. DATE OF OPERATION**

**19b. MAJOR FINDINGS OF OPERATION**

**20. AUTOPSY?** YES [ ] NO [X]

**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) m.

**21e. INJURY OCCURRED** WHILE AT WORK [ ] NOT WHILE AT WORK [ ]

**21f. HOW DID INJURY OCCUR?** 4222

22. *I hereby certify that I attended the deceased from* JAN. 24 *, 1955, to* JAN 30 *, 1955, that I last saw the deceased alive on* JAN 30 *, 1955, and that death occurred at* 3.00 A.M. *from the causes and on the date stated above.*

**23a. SIGNATURE** (Degree or title): C. W. Max Well M.D.

**23b. ADDRESS**: 4500 Olive

**23c. DATE SIGNED**: 1-31-55

**24a. BURIAL, CREMATION, REMOVAL** (Specify): Removal

**24b. DATE**: Feb. 1, 1955

**24c. NAME OF CEMETERY OR CREMATORY**: Cauthersville Cem.,

**24d. LOCATION** (City, town, or county) (State): Cauthersville, Mo.

DATE REC'D BY LOCAL REG.: JAN 31 1955

REGISTRAR'S SIGNATURE: J. Earl Smith, M.D.

25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS: Jos. W. Clark 1125 Hodiamont ave.
S.P. (Licensed Embalmer's Statement on Reverse Side)

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

4500 Olive St.,
9-12 P.M.

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was emba

by me, or by ....., Student Embalmer No.....

working under my personal supervision..

Student.....
Signature of Student Embalmer

Signed. Alfred F. Boedeker

Licensed Embalmer No. 2663

P. O. Address 1125 Hodiamon

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

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

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