

FILED JUN 1 1956

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

16708

State File No. \_\_\_\_\_

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. 146 PRIMARY REG. DIST. NO. 3026 Registrar's No. 246

1. PLACE OF DEATH a. COUNTY <u>Jackson</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <u>Mo</u> b. COUNTY <u>Lafayette</u>	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Independence</u>		c. CITY OR TOWN <u>Oak Grove</u>	d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
c. LENGTH OF STAY (in this place) <u>6 days</u>		e. STREET ADDRESS (If rural, give location) <u>2 Miles East R.F.D. 0540</u>	
d. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION <u>Independence San &amp; Hospital</u>			

3. NAME OF DECEASED (Type or Print)	a. (First) <u>William</u>	b. (Middle) <u>John</u>	c. (Last) <u>Richardson</u>	4. DATE OF DEATH (Month) (Day) (Year) <u>May 26 1956</u>
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5. SEX <u>Male</u>	6. COLOR OR RACE <u>Wh</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>	8. DATE OF BIRTH <u>April 15 1872</u>	9. AGE (In years last birthday) <u>84</u>	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 12 HRS. Hours _____ Min. _____
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>Owner</u>	11. BIRTHPLACE (City and State or Foreign Country) <u>Gailesburg Ills</u>	12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
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13a. FATHER'S NAME <u>George W Richardson</u>	13b. MOTHER'S MAIDEN NAME <u>Jane McClure</u>	14. NAME OF HUSBAND OR WIFE <u>Lucy J Richardson</u>
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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>none</u>	17. INFORMANT'S SIGNATURE OR NAME <u>Mrs Richardson</u>	ADDRESS _____
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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, asthma, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH <u>7 day</u>
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Cornway Fluorosis</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. _____			

19a. DATE OF OPERATION _____	19b. MAJOR FINDINGS OF OPERATION _____	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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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) <u>4201</u>
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour) _____	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? _____
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22. I hereby certify that I attended the deceased from 5-18 1956, to 5-24 1956, that I last saw the deceased alive on 5-25 1956, and that death occurred at 6:30 AM, from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) <u>James W. Williams M.D.</u>	23b. ADDRESS <u>Oak Grove Mo</u>	23c. DATE SIGNED <u>5-26-56</u>
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24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	24b. DATE <u>5-28 1956</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Oak Grove Cem</u>	24d. LOCATION (City, town, or county) (State) <u>Oak Grove Mo</u>
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DATE REC'D BY LOCAL REG. <u>5-28-56</u>	REGISTRAR'S SIGNATURE <u>[Signature]</u>	25. FUNERAL DIRECTOR'S SIGNATURE <u>Webb Funeral Home</u>	ADDRESS <u>Oak Grove Mo</u>
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(Deceased Emballer's Statement on Reverse Side) Present

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

54

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.....  
Signature of Student Embalmer

Signed Webb Funeral Home  
RB Webb  
Licensed Embalmer No. 238  
P. O. Address Blue Springs

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

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