

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **3295**

BIRTH NO. FILED JAN 14 1957 REG. DIST. NO. **324** PRIMARY REG. DIST. NO. **3072** Registrar's No. **5**

1. PLACE OF DEATH a. COUNTY Saline		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY Texas	
b. CITY (If outside corporate limits, write RURAL and give town or township) Marshall		c. CITY OR TOWN Summersville	d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. LENGTH OF STAY (in this place) 1 day		e. STREET ADDRESS (If rural, give location) Streets not numbered 1070	
d. FULL NAME OF HOSPITAL OR INSTITUTION Fitzgibbon Hospital			
3. NAME OF DECEASED (Type or Print) a. (First) Katherine b. (Middle) Richards c. (Last) Charles		4. DATE OF DEATH (Month) (Day) (Year) Jan. 9, 1957	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed	8. DATE OF BIRTH Aug. 30, 1866
9. AGE (In years last birthday) 90		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	11. BIRTHPLACE (City and State or Foreign Country) Jerseyville, Illinois
10a. USUAL OCCUPATION		10b. KIND OF BUSINESS OR INDUSTRY Own Home	12. CITIZEN OF WHAT COUNTRY? USA
13a. FATHER'S NAME John Lamb Richards		13b. MOTHER'S MAIDEN NAME Mary Ann Corbett	14. NAME OF HUSBAND OR WIFE -----
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None	17. INFORMANT'S SIGNATURE OR NAME ADDRESS Mrs. Earl Gorrell Malta Bend, Mo.
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) Cardiac Failure ANTECEDENT CAUSES DUE TO (b) Pneumonia, hypertatic 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? 2 YES <input type="checkbox"/> NO <input checked="" 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)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from 8 Jan, 1957 , to 9 Jan, 1957 , that I last saw the deceased alive on 8 Jan, 1957 , and that death occurred at 1-45 P. M. , from the causes and on the date stated above.			
23a. SIGNATURE D. F. Lichen M.D. (Degree or title)		23b. ADDRESS Marshall Mo.	23c. DATE SIGNED 9 Jan 1957
24a. BURIAL, CREMATION, REMOVAL (Specify) Removal	24b. DATE Jan. 9, 1957	24c. NAME OF CEMETERY OR CREMATORY Summersville Cemetery	24d. LOCATION (City, town, or county) (State) Summersville, Mo.
DATE REC'D BY LOCAL REG. 1-9-57	REGISTRAR'S SIGNATURE Cecil S. Reed	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Campbell-Lewis MARSHALL Mo.	

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

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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.....
Signature of Student Embalmer

Signed..... *R.W. Campbell M.*
Licensed Embalmer No. *346*

P. O. Address *Marshall*

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.