

FILED AUG 30 1957

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

29942

STATE FILE NUMBER

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 7418

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis		c. CITY OR TOWN Wellston 4311 0	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION DePaul Hosp.		d. STREET ADDRESS 6214 Plymouth	
3. NAME OF DECEASED (Type or print) First Middle Last Walter P. Richardson		4. DATE OF DEATH Month Day Year 8 6 57	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 21, 1873
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Inspector - Ret.		10b. KIND OF BUSINESS OR INDUSTRY Railroad	11. BIRTHPLACE (City and state or country) Owensville, Mo.
13. FATHER'S NAME Benjamin Richardson		14. MOTHER'S MAIDEN NAME - Johnson	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) No		16. SOCIAL SECURITY NO. none	17. INFORMANT Address Mr. Bert C. Richardson 4020 Healy Court
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Intestinal obstruction 2hrs Paralytic ileus 24hrs Infectious Infection 2 1/2 hrs Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) Paralytic ileus DUE TO (c) Infectious Infection PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Arteriosclerotic heart disease Subacute Myocardial Disease			INTERVAL BETWEEN ONSET AND DEATH 2 hrs 24 hrs 2 1/2 hrs
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour Month, Day, Year a. m. p. m.			
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) July 24, 1957	20f. CITY, TOWN, OR LOCATION COUNTY STATE 8-6-57 8-7-57
21. I attended the deceased from July 24-1957 to 8/6/57 and last saw him alive on 8/7/57 Death occurred at 8:10 P. m. on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE John B. Meyers (Degree or title) M.D.		22b. ADDRESS 634 N. Grand Blvd.	22c. DATE 8/3/57
23a. BURIAL, CREMATION, REMOVAL (Specify) removal	23b. DATE 8/9/57	23c. NAME OF CEMETERY OR CREMATORY Memorial Park Cemetery	23d. LOCATION (City, town, or county) (State) St. Louis County Mo.
24. FUNERAL DIRECTOR Drehmann-Harral		25. DATE RECD. BY LOCAL REG. 1905 Union AUG 8 '57	26. REGISTRAR'S SIGNATURE J. Carl Smith M.D.

(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE
diseases in Part I must be causally related. Coroner cannot certify to a death due to natural causes.

Dr. J. B. Meyers
Missouri Theatre Bldg.

Hrs. 1 - 6 Thurs.

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was e
by me, or by Student Embalmer No.....
working under my personal supervision..

Student.....
Signature of Student Embalmer

Signed *Warren A. Carve*.....

Licensed Embalmer No. *35*

P. O. Address.....

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING.
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.