

pt. Health,
, & Welfare
S. Public
with Service

Y. S. 300
ev. 1-57

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed.
All diseases in Part I must be causally related.

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

FILED NOV 6 1957

38043

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 9609

STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY <u>St Louis Mo</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>St Louis</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>ST. LOUIS, MISSOURI</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN <u>45970 Webster Groves Mo</u> Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>04 BARNES HOSPITAL</u> Length of stay in lb <u>4 days</u>		d. STREET ADDRESS (If outside, give location) <u>27 630 Bell Avenue</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>ELLA</u> Middle <u>NMN</u> Last <u>RICHARDSON</u>			4. DATE OF DEATH Month <u>OCTOBER</u> Day <u>12</u> Year <u>1957</u>
5. SEX <u>3</u> <u>Female</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 25 1887</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housework</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Domestic</u>	11. BIRTHPLACE (City and state or country) <u>Bowles Missouri</u>
13a. FATHER'S NAME <u>George Buirl</u>		13b. MOTHER'S MAIDEN NAME <u>Fannie Morris</u>	14. NAME OF HUSBAND OR WIFE <u>William Richardson</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>None</u>	17. INFORMANT Address <u>Sarah Bynum 630 Bell Avenue</u>
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>G. I. BLEEDING</u>			INTERVAL BETWEEN ONSET AND DEATH <u>4 MOS.</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) <u>DIVERTICULOSIS, LARGE INTESTINE</u>			
DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a).			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT SUICIDE HOMICIDE <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.) <u>572.1</u>	
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.)	
		20f. CITY, TOWN, OR LOCATION COUNTY STATE	
21. I attended the deceased from <u>OCT. 9, 1957</u> to <u>OCT 12, 1957</u> and last saw her alive on <u>OCT. 12, 1957</u> Death occurred at <u>6:55 A.M.</u> m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Charge or title) <u>C. J. Demillion, M.D.</u>		22b. ADDRESS <u>BARNES HOSPITAL</u>	
		22c. DATE SIGNED <u>10-12-57</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>10-18-57</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Father Dickson Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Crestwood Missouri</u>	
24. FUNERAL DIRECTOR ADDRESS <u>T.T. Vandell & Sons Funeral Home</u>		25. DATE RECD. BY LOCAL REG. <u>OCT 15 57</u>	
		26. REGISTRAR'S SIGNATURE <u>J. Carl Smith MO</u>	

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE
MEDICAL CERTIFICATION

177 East 9th Home Avenue
Webster Groves 19776
(Licensed Embalmer's Statement on Reverse Side)

J. Carl Smith MO
2283

91085

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 *Frederic J. Yardee*

Licensed Embalmer No. *4243*
P. O. Address *1308 Lundy
Nebitt Ave. M*

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.