

THE DIVISION OF HEALTH AND HOSPITALS  
STANDARD CERTIFICATE OF DEATH

58-040556

STATE FILE NUMBER

FULL NOV 26 1958

Registration District No. 170 Primary Registration District No. \_\_\_\_\_ Registrar's No. 162

1. PLACE OF DEATH a. COUNTY <u>Laclede</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Laclede</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Washington T.S.</u>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	c. CITY OR TOWN <u>Russ</u>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Russ</u>		Length of stay in lb <u>25 Years</u>	d. STREET ADDRESS (If outside, give location) <u>Plato Star Rt.</u>
3. NAME OF DECEASED (Type or print) First <u>FLORENCE</u> Middle <u>ELIZABETH</u> Last <u>RICHART</u>			4. DATE OF DEATH Month <u>Nov.</u> Day <u>12,</u> Year <u>1958</u>
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</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>June 19, 1892</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Domestic</u>	11. BIRTHPLACE (City and state or country) <u>Barnard, Mo.</u>
13a. FATHER'S NAME <u>Lewis Hocker</u>		13b. MOTHER'S MAIDEN NAME <u>Sara Jackson</u>	14. NAME OF HUSBAND OR WIFE <u>John Richart</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>Mr. John Richart, Russ, Mo.</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>acute pulmonary embolus</u>			INTERVAL BETWEEN ONSET AND DEATH <u>instantaneous</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>phlebotrombosis at lower ext.</u>			<u>2 wks.</u>
DUE TO (c) <u>sprain + contusion at ankle +</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>left side of abdomen.</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT <input checked="" 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.) <u>Fell while carrying stick of wood and hurt right ankle + left side. Received treatment in office</u>	
20c. TIME OF INJURY Hour Month, Day, Year a.m. <u>11:40 AM</u> p.m. <u>10-25-58</u>		20d. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>at farm home</u>	
20d. INJURY OCCURRED WHILE AT WORK <input checked="" type="checkbox"/> NOT WHILE WORK <input type="checkbox"/>		20e. CITY, TOWN, OR LOCATION <u>Oakland Star Rt. Lebanon, Laclede, Mo.</u>	
21. I attended the deceased from <u>11-1-58</u> to <u>11-12-58</u> and last saw her alive on <u>11-8-58</u> Death occurred at <u>1:00 P.</u> m on the date stated above; and to the best of my knowledge, from the causes stated.		22a. SIGNATURE (Degree or title) <u>R. B. Hurst, M.D.</u>	
22b. ADDRESS <u>Lebanon, Mo.</u>		22c. DATE SIGNED <u>11-14-58</u>	
23a. BURIAL, CREMATION, REMOVAL (specify) <u>Burial</u>	23b. DATE <u>11/15/58</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Hew Hope Cemetery</u>	23d. LOCATION (City, town, or county) (State) <u>Laclede County Missouri</u>
24. FUNERAL DIRECTOR <u>S. R. Palmer Lebanon, Mo.</u>		25. DATE RECD. BY LOCAL REG. <u>11-15-1958</u>	26. REGISTRAR'S SIGNATURE <u>Hella G. Day</u>

(Licensed Embalmer's Statement on Reverse Side)

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.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

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 Stanley R. Palmer

Licensed Embalmer No. 4810  
P. O. Address Lebanon, Mo

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.