

R.I. DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-025788

FILED VS JUL 21 1959

Registration District No. 71 Primary Registration District No. 4-263 Registrar's No. 34

STATE FILE NUMBER

DED

| | | | | | | | | |
|---|--|---|--|---|---|--|--|--|
| 1. PLACE OF DEATH a. COUNTY <u>Lafayette</u> | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MO</u> b. COUNTY <u>Jackson</u> | | | | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Napoleon</u> | | Length of stay in 1b <u>1/2</u> hour | | c. CITY OR TOWN <u>Kansas City Mo</u> | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | | |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Highway 24 & Napoleon business route</u> | | | | d. STREET ADDRESS (If outside, give location) <u>1408 E 19th St</u> | | Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> | | |
| 3. NAME OF DECEASED (Type or print) First <u>William</u> Middle <u>Richardson</u> Last <u>Richardson</u> | | | | 4. DATE OF DEATH Month <u>July</u> Day <u>12</u> Year <u>1959</u> | | | | |
| 5. SEX <u>Male</u> | | 6. COLOR OR RACE <u>negro</u> | | 7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Single <input checked="" type="checkbox"/> | | 8. DATE OF BIRTH <u>1/18/1909</u> | | |
| 9. AGE (last birthday) <u>50</u> | | IF UNDER 1 YEAR Months <u> </u> Days <u> </u> | | IF UNDER 24 HR Hours <u> </u> Min. <u> </u> | | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u> | | | 10b. KIND OF BUSINESS OR INDUSTRY | | | 11. BIRTHPLACE (City and state or country) <u>Forrest City, Arkansas U.S.A.</u> | | |
| 12. CITIZEN OF WHAT COUNTRY | | | 13a. FATHER'S NAME <u>William P. Richardson</u> | | 13b. MOTHER'S MAIDEN NAME <u>Katie Miles</u> | | 14. NAME OF HUSBAND OR WIFE <u>None</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>510-14-8884</u> | | | 17. INFORMANT Address <u>Mrs. Katie Miles, Olean, 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>Motor Car wreck, FV curved</u> <u>pin, Basal skull fracture</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u> </u> DUE TO (c) <u> </u> | | | | | | | INTERVAL BETWEEN ONSET AND DEATH | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) | | | | | | PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown | | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20a. ACCIDENT SUICIDE HOMICIDE <input checked="" 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>Motor car in which he was riding left road & was wrecked</u> | | | | |
| 20c. TIME OF INJURY Hour <u> </u> a.m. <u> </u> p.m. | | 20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> | | 20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>No 24 Highway</u> | | 20f. CITY, TOWN, OR LOCATION COUNTY STATE <u>Napoleon Lafayette Mo</u> | | |
| 21. I attended the deceased from <u> </u> and last saw him alive <u> </u> Death occurred at <u> </u> on the date stated above, and to the best of my knowledge, from the causes stated. | | | | | | | | |
| 22a. SIGNATURE (Degree or title) <u>W. Martin MD Coroner</u> | | | | 22b. ADDRESS <u>Olesea Mo</u> | | 22c. DATE SIGNED <u>7-13-59</u> | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u> | | 23b. DATE <u>7/13/1959</u> | | 23c. NAME OF CEMETERY OR CREMATORY <u>Greenridge Cemetery</u> | | 23d. LOCATION (City, town, or county) (State) <u>Eldon, Missouri</u> | | |
| 24. FUNERAL DIRECTOR ADDRESS <u>Phillips Funeral Home Eldon, Mo.</u> | | | | 25. DATE RECD. BY LOCAL REG. <u>7/13/59</u> | | 26. REGISTRAR'S SIGNATURE <u>Emma Davidson</u> | | |

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

JUL 23 1959

JUL 27 1959

STATEMENT BY LICENSED EMBALMER

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

Student _____
Signature of Student Embalmer

Signed Dr. Blair Sheppard

Licensed Embalmer No. 4179

P. O. Address Wellington, N.J.

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.