

# RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

## 59-029799

FILED VS SEP 11 1959

Registration District No. 209 Primary Registration District No. 3043 Registrar's No. 263

STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY <u>Marion</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Marion</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Hannibal</u>		Length of stay in 1b <u>45 yrs.</u>	c. CITY OR TOWN <u>Hannibal</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>Levering Hospital</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>1229 Bird St.</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <u>DANIEL</u> Middle <u>PAUL</u> Last <u>RICHART</u>			4. DATE OF DEATH Month <u>8</u> Day <u>28</u> Year <u>59</u>			
5. SEX <u>Male</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>10-20-94</u>	9. AGE (last birthday) <u>64 yrs.</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>Engineer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Mo. State Hwy.</u>		11. BIRTHPLACE (City and state or country) <u>Ladonia, Mo.</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>
13a. FATHER'S NAME <u>James O. Richart</u>		13b. MOTHER'S MAIDEN NAME <u>Sarah Jane Chowning</u>		14. NAME OF HUSBAND OR WIFE <u>Thelma Richart</u>		

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)   (If yes, give war or dates of service) <u>Yes</u> <u>W.W.I</u>	16. SOCIAL SECURITY NO. <u>498-34-8992</u>	17. INFORMANT <u>Mrs. Thelma Richart, 1229 Bird St.</u> Address <u>Hannibal, 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>Bronchogenic Carcinoma</u>		INTERVAL BETWEEN ONSET AND DEATH <u>6 mths</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____		

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 <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 _____ a.m. _____ p.m. _____ Month, Day, Year _____			
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 7-10-48 to 8-28-59 and last saw xx him alive on 8-28-59  
Death occurred at 4:00 P.m. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <u>M. D. [Signature]</u> (Degree or title)	22b. ADDRESS <u>100 N. Sixth, Hannibal, Mo.</u>	22c. DATE SIGNED <u>9-1-59</u>
---	---	--------------------------------

23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>8-31-59</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Grand View Burial Pk.</u>	23d. LOCATION (City, town, or county) (State) <u>Hannibal, Mo.</u>
---	--------------------------	---	--

24. FUNERAL DIRECTOR <u>Jack Schwartz - Hannibal, Mo.</u> ADDRESS _____	25. DATE RECD. BY LOCAL REC. <u>9-1-59</u>	26. REGISTRAR'S SIGNATURE <u>[Signature]</u>
---	--	--

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

**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

*Jack Lehman*

Licensed Embalmer No.

*7490*

P. O. Address

*Hunter*

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.