

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 40706
Registrar's No. 85

Registration District No. 75

Primary Registration District No. 6070

1. PLACE OF DEATH
(a) County St. Francois Parish, La
(b) City or town RFD #1, Bonne Terre, Mo
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution V
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____
(Specify whether _____)
In this community _____
years, months or days 2 1/2

3. (a) PRINT FULL NAME LEWIS THOMAS RICHARDSON
3. (b) If veteran, name war no
3. (c) Social Security No. none

4. Sex Male
5. Color or race White
6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife Mary Richardson
6. (c) Age of husband or wife if alive 70 years
7. Birth date of deceased Nov. 21 1867
(Month) (Day) (Year)

8. AGE: Years 72 Months 0 Days 8
If less than one day _____ hr. _____ min.

9. Birthplace Hazel Run, Missouri
(City, town, or county) (State or foreign country)

10. Usual occupation Farming

11. Industry or business _____
MOTHER FATHER { 12. Name Booker Richardson
13. Birthplace Wisconsin
14. Maiden name Julia Jones
15. Birthplace Bonne Terre, Missouri
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature W. Thomas Richardson
(b) Address RFD #1, Bonne Terre, Mo

17. (a) Rural (b) Date thereof Dec 1 1939
(Burial, cremation, or removal) (Month) (Day) (Year)

18. (a) Signature of funeral director Richardson Crematory
(b) Address 313 Benton Bonne Terre, Mo

19. (a) Dec 1, 1939 (b) N. W. Hawkins
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County St. Francois
(c) City or town Bonne Terre
(If outside city or town limits, write "RURAL")
(d) Street No. Rural
(If rural, give location)
(e) If foreign born, how long in U. S. A.? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov day 29
year 1939 hour 6 minute A. M.
21. I hereby certify that I attended the deceased from Nov - 23 - 1939 to Nov 29 - 1939
that I last saw him alive on Nov - 23 - 1939
and that death occurred on the date and hour stated above.

Immediate cause of death Chronic nephritis
Duration 1920
Due to unknown

Due to _____
Other conditions _____
(Include pregnancy within 3 months of death)

PHYSICIAN _____
Major findings: Of operations _____
Of autopsy _____
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify) _____
(b) Date of occurrence _____
(c) Where did injury occur? _____
(City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place?

While at work? _____ (Specify type of place) (e) Means of injury _____
23. Signature P. E. Evans (M. D. or other) _____
Address Bonne Terre, Mo Date signed 12-5-39

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.....

....., Registered Apprentice No.....

working under my personal supervision.

Signed.....

A. J. Claywell

Licensed Embalmer No. *3706*

P. O. Address *Princeton, Tenn. 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 this body is not embalmed, above space should be left blank.