

198-01-2-198-0-1

TEXAS DEPARTMENT OF HEALTH
BUREAU OF VITAL STATISTICS

420.1 25
55206

STATE OF TEXAS

CERTIFICATE OF DEATH

STATE FILE NO.

NOTE THE INFORMATION CALLED FOR ON THE REVERSE SIDE

1. PLACE OF DEATH a. COUNTY Robertson			2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Texas b. COUNTY Robertson		
b. CITY (If outside corporate limits, write RURAL and give OR TOWN Franklin)			c. CITY (If outside corporate limits, write RURAL and give precinct no.) 6 OR TOWN Easterly		
c. LENGTH OF STAY (in this place) 2 hrs.			d. STREET ADDRESS (If rural, give location)		
d. FULL NAME OF HOSPITAL OR INSTITUTION Dr. Joe Sharp's Office					
3. NAME OF DECEASED (Type or Print) a. (First) Carl		b. (Middle) C		c. (Last) Richardson	
4. DATE OF DEATH November 14 1949					
5. SEX Male		6. COLOR OR RACE White		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Divorced	
8. DATE OF BIRTH December 21 1887		9. AGE YEARS 61		MONTHS 10 DAYS 23	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ranchman		10b. KIND OF BUSINESS OR INDUSTRY Renshing		11. BIRTHPLACE (State or foreign country) Texas	
12. FATHER'S NAME James M. Richardson		BIRTHPLACE Texas		13. MOTHER'S MAIDEN NAME Janie Cobb	
BIRTHPLACE Texas		14. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)			
15. SOCIAL SECURITY NO.		16. INFORMANT'S SIGNATURE <i>J.M. Richardson</i>			
17. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) <i>*This does not mean the mode of dying, such as heart failure, asphyxia, etc. It means the disease, injury, or complication which caused death.</i>					
MEDICAL CERTIFICATION					
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Coronary occlusion					
ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____					
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.					
18a. DATE OF OPERATION		18b. MAJOR FINDINGS OF OPERATION		19. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT SUICIDE HOMICIDE (Specify) None		20b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		20c. (CITY, TOWN, OR PRECINCT NO.) (COUNTY) (STATE)	
20d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		20e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20f. HOW DID INJURY OCCUR?	
21. I hereby certify that I attended the deceased from _____, 19____, to Nov. 14, 1949 , that I last saw the deceased alive on 11-14, 1949 , and that death occurred at 4:35 p.m. , from the causes and on the date stated above.					
22a. SIGNATURE <i>Joseph E. Sharp M.D.</i>		22b. ADDRESS Franklin, Texas		22c. DATE SIGNED 11-21-49	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE November 16, 1949		23c. NAME OF CEMETERY OR CREMATORY Easterly	
23d. LOCATION (City, town, or county) Easterly		(State) Texas		24. FUNERAL DIRECTOR'S SIGNATURE J.I. Riddle & Co	
25a. REGISTRAR'S FILE NO. 137-		25b. DATE REC'D BY LOCAL REGISTRAR 11-21-49		25c. REGISTRAR'S SIGNATURE <i>Eunice Mitchell</i>	

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REC'D DEC 7 1949
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