

REGISTRATION DISTRICT NO. *180*
 REGISTERED NUMBER *70-68*

STATE OF ILLINOIS

STATE FILE NUMBER *170-00455*

MEDICAL CERTIFICATE OF DEATH

DECLASED—NAME FIRST MIDDLE LAST SEX DATE OF DEATH (MONTH, DAY, YEAR)

JOHN WILLIAM RICHARDSON 2 Male 3. *1-10-70* Jan. 10, 1970

1. RACE (SPECIFY) *White* AGE—LAST BIRTHDAY (YRS) *77* UNDER 1 YEAR: MO. DAYS UNDER 1 DAY: HOURS MIN. DOB OF BIRTH (MM/DD/YY) *1892* PLACE OF DEATH COUNTY *Williamson*

4. CITY, TWP. OR ROAD DISTRICT NUMBER *Marion* 5b. *Yes* 7d. *Veterans Administration Hospital* (IF NOT IN EITHER, GIVE STREET AND NUMBER)

7b. BIRTHPLACE (STATE OR FOREIGN COUNTRY) *Illinois* 9. U.S.A. 10. *Widowed* 11. NAME OF SURVIVING SPOUSE (IF WIFE, GIVE MAIDEN NAME)

8. SOCIAL SECURITY NUMBER *356-16-6052* 13a. *Salesman* 13b. *Insurance* 13c. *Yes* 13d. *W I*

12. RESIDENCE STATE COUNTY CITY, TWP. OR ROAD DISTRICT NO. INSIDE CITY (YES/NO) STREET AND NUMBER

Illinois Madison 14c. *Edwardsville* 14d. *Yes* 14n. *1034 Florida*

FATHER—NAME FIRST MIDDLE LAST MOTHER—MAIDEN NAME FIRST MIDDLE LAST

William Richardson 16. *Alice Gott*

17a. INFORMANT'S SIGNATURE *T. L. SHREVE* RELATIONSHIP *---* MAILING ADDRESS (STREET AND NO. OR R. F. D., CITY OR TOWN, STATE, ZIP) *VA Hospital, Marion, Ill. 62959*

PART I. DEATH WAS CAUSED BY: (ENTER ONLY ONE CAUSE PER LINE FOR (a), (b), AND (c))

18. IMMEDIATE CAUSE

(a) *Arteriosclerotic Heart Disease* Years *---*

CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (b) *Arteriosclerosis, general* Years *---*

(c) *Bronchitis, emphysema, and pulmonary tuberculosis, arrested.* 19a. *Yes* 19b. *Yes*

PART II. OTHER SIGNIFICANT CONDITIONS: CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO CAUSE GIVEN IN PART I (a)

DATE OF OPERATION, IF ANY; MAJOR FINDINGS OF OPERATION

20. I CERTIFY THAT TO THE BEST OF MY KNOWLEDGE THIS DEATH OCCURRED AT *5:05 a. m.* NOTE: IF AN INJURY WAS INVOLVED IN THIS DEATH, THE CORONER MUST BE NOTIFIED.

21. ATTENDED THE DECEASED FROM: MONTH DAY YEAR TO MONTH DAY YEAR AND LAST DAY (TIME) MONTH DAY YEAR

1 16 70 TO 1 18 70

21a. SIGNATURE *Charles P. ...* DATE SIGNED (MONTH, DAY, YEAR) *1-18-70* ILLINOIS LICENSE NUMBER

22a. MAILING ADDRESS—CERTIFIER *Veterans Administration Hospital, Marion, Ill. 62959* STREET AND NUMBER OR R. F. D. CITY OR TOWN STATE ZIP

23. BURIAL, CREMATION, REMOVAL (SPECIFY) *Burial* CEMETERY OR CREMATORY—NAME *Odd Fellows* LOCATION *DuQuoin, Ill.* CITY OR TOWN STATE DATE (MONTH, DAY, YEAR) *1/20/1970*

24a. FUNERAL HOME NAME *REAL FUNERAL HOME, DuQuoin, Ill. 62832* STREET AND NUMBER OR R. F. D. CITY OR TOWN STATE ZIP

25a. FUNERAL DIRECTOR'S SIGNATURE *...* FUNERAL DIRECTOR'S ILLINOIS LICENSE NUMBER *31-5394*

26a. LOCAL REGISTRAR'S SIGNATURE *...* DATE RECD. BY LOCAL REGISTRAR (MONTH, DAY, YEAR) *January 21, 1970*