

✓

STATE OF OHIO  
DEPARTMENT OF HEALTH  
DIVISION OF VITAL STATISTICS  
CERTIFICATE OF DEATH

1 PLACE OF DEATH Lucas Registration District No. 769 File No. 65652  
 County.....  
 Township..... Primary Registration District No. 8349 Registered No. 270  
 or Village..... No. .... St., ..... Ward  
 or City of Toledo (If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Dr. J. Lee Richmond Did Deceased Serve in U. S. Navy or Army.....  
 (a) Residence. No. 746 Gove Place St., ..... Ward. ....  
 (Usual place of abode) (If nonresident give city or town and State)  
 Length of residence in city or town where death occurred 39 yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 Single, Married, Widowed or Divorced (write the word) Married

5a If married, widowed or divorced  
 HUSBAND of Mary Chapman Richmond  
 (or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 5, 1857

7 AGE Years Months Days If LESS than 1 day.....hrs. or.....min.  
72 4 26

8 OCCUPATION OF DECEASED Professor  
 (a) Trade, profession, or particular kind of work  
 (b) General nature of industry, business, or establishment in which employed (or employer) University of Toledo  
 (c) Name of employer

9 BIRTHPLACE (city or town) Sheffield  
 (State or country) Ohio

10 NAME OF FATHER Cyrus R. Richmond  
 11 BIRTHPLACE OF FATHER (city or town) Maryland  
 (State or country) N. Y.  
 12 MAIDEN NAME OF MOTHER Eliza Tinan  
 13 BIRTHPLACE OF MOTHER (city or town) Chapley  
 (State or country) Maine

14 Informant Mrs. J. L. Richmond  
 (Address) Toledo, Ohio

15 Filed 10 2 25 19 Sam Smith REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day and year) Oct 1 19 29

17 I HEREBY CERTIFY, That I attended deceased from Sept 1, 19 29, to Oct 1, 19 29, that I last saw him alive on Sept 30, 19 29, and that death occurred, on the date stated above, at 12:30 A. m.

The CAUSE OF DEATH\* was as follows:  
Cerebral Thrombosis

CONTRIBUTORY (SECONDARY) Arteriosclerosis  
 (duration) ..... yrs. .... mos. .... ds.

18 Where was disease contracted \_\_\_\_\_  
 if not at place of death? \_\_\_\_\_

Did an operation precede death? no Date of \_\_\_\_\_

Was there an autopsy? no

What test confirmed diagnosis? \_\_\_\_\_

(Signed) Glenn H. Reamer, M. D.  
10-1, 19 29 (Address) 32 Schenck St.

\*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL. (See reverse side for additional space.)

19 PLACE of Woodlawn, Cremation, \_\_\_\_\_ DATE OF BURIAL 10/3/29

20 UNDERTAKER The W. Bennett Co ADDRESS Toledo O

20a WAS THE BODY EMBALMED? Yes EMBALMER'S LICENSE NO. 3588