

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

Registration District No. **14**

Primary Registration District No. **1000**

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH:

(a) County Buchanan

(b) City or town St. Joseph
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:
Missouri Methodist Hospital
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 5 days
(Specify whether years, months or days)

In this community 5 days

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Holt

(c) City or town Mound City
(If outside city or town limits, write "RURAL")

(d) Street No. 1
(If rural, give location)

(e) Citizen of foreign country? No. (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME Liza Jane Brickey

3. (b) If veteran, name war None

3. (c) Social Security No. None

4. Sex Female 5. Color or race White

6. (a) Single, widowed, married, divorced Widow 2

6. (b) Name of husband or wife Lucius Brickey

6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased February 28 1870
(Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
<u>77</u>	<u>0</u>	<u>8</u>	hr. _____ min. _____

9. Birthplace Washington County, Indiana
(City, town, or county) (State or foreign country)

10. Usual occupation Housewife

11. Industry or business At Home

MOTHER FATHER

12. Name Joshua Warriner

13. Birthplace Unknown Indiana
(City, town, or county) (State or foreign country)

14. Maiden name Elizabeth Shields

15. Birthplace Unknown Indiana
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Elizabeth Sullender

(b) Address R.F.D. #2 St. Joseph, Mo.

17. (a) Burial (b) Date thereof Mar. 7, 1947
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Mound City, Mo.

18. (a) Signature of funeral director Walter Meierhoffer

(b) Address 1946 Calhoun St., St. Joseph, Mo.

19. (a) 3-11-47 (b) L. B. Jenkins
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 6
year 1947 hour 2 minute 16 P.M.

21. I hereby certify that I attended the deceased from Feb 27 1947
19____ to Mar 6 - 47 19____
that I last saw h. or alive on 3-6-47 19____
and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral hemorrhage -

Due to Hypertension _____ year _____

Due to and operation for fracture of femur _____ 2 days

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

PHYSICIAN

Major findings: Fracture of femur

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) accident 0 4 4

(b) Date of occurrence 2-22-47

(c) Where did injury occur? Mound City Holt Mo.
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place?
Home

While at work? no (Specify type of place)

(c) Means of injury fall

23. Signature Paul Jorgensen (M. D. or other) _____
Address St Joseph, Mo Date signed 3-8-47

MAY 15 1947

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.....

Albert P. Harrington

Licensed Embalmer No. 3258 Missouri.....

P. O. Address St. Joseph, 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, fact should be so stated above.