

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

14087

State File No.

FILED APR 25 1952

BIRTH NO. _____ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003** Registrar's No. **3206**

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

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Missouri b. COUNTY	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis, 2139	
d. FULL NAME OF HOSPITAL OR INSTITUTION St. Louis State Hospital		d. STREET ADDRESS (If rural, give location) 13 5400 Arsenal St.	
3. NAME OF DECEASED (Type or Print) a. (First) JOSEPH b. (Middle) c. (Last) BRICKER		4. DATE OF DEATH (Month) (Day) (Year) April 3, 1952	
5. SEX 0 male	6. COLOR OR RACE white	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) single 0	8. DATE OF BIRTH July 7, 1915
9. AGE (In years last birthday) 36		IF UNDER 1 YEAR Months	IF UNDER 1 YEAR Days
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Proprietor		10b. KIND OF BUSINESS OR INDUSTRY Retail shoes	11. BIRTHPLACE (City and State or Foreign Country) St. Louis, Mo. 0
12. CITIZEN OF WHAT COUNTRY? USA		13a. FATHER'S NAME Morris Bricker	
13b. MOTHER'S MAIDEN NAME Jennie Brown		14. NAME OF HUSBAND OR WIFE None	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No No		16. SOCIAL SECURITY NO. Unk	
17. INFORMANT'S SIGNATURE OR NAME Mrs. Jennie Bricker		ADDRESS 6435 San Bonit	
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Gastro intestinal infection DUE TO (b) etiology undetermined DUE TO (c) Diabetes Mellitus II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	
INTERVAL BETWEEN ONSET AND DEATH 3/20/52 3/31/52		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY?
21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? 2100 X	
22. I hereby certify that I attended the deceased from 11/1/52 , to Apr 4 , 19 52 , that I last saw the deceased alive on Apr 4 , 19 52 , and that death occurred at 7:50p m., from the causes and on the date stated above.			
23a. SIGNATURE J. Proun		23b. ADDRESS 5400 Arsenal St.	23c. DATE SIGNED 4/4/52
24a. BURIAL, CREMATION, REMOVAL (Specify) removal	24b. DATE 4/6/52	24c. NAME OF CEMETERY OR CREMATORY BETH HAM HAG	24d. LOCATION (City, town, or county) (State) LADUE MISSOURI
DATE REC'D BY LOCAL REG. APR 5 1952	REGISTRAR'S SIGNATURE J. Earl Smith, M.D.	25. FUNERAL DIRECTOR'S SIGNATURE Berger Memorial	
		ADDRESS 4715 McPherson	

STATEMENT BY LICENSED EMBALMER

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I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by _____

Student Embalmer No. _____

working under my personal supervision.

Student
Student Embalmer

Signed _____

Paul A. Dunning

Licensed Embalmer No. 7529

P. O. Address _____

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.