

**THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH**

FILED JUL 31 1953

26813

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State File No.

5910

BIRTH NO. _____		REG. DIST. NO. _____		PRIMARY REG. DIST. NO. _____		Registrar's No. _____	
1. PLACE OF DEATH a. COUNTY _____				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>St. Francois</u>			
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>St. Louis, Missouri</u>		c. LENGTH OF STAY (in this place) _____		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Bismarck</u>		d. STREET ADDRESS (If rural, give location) <u>0940</u> <u>1</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>St. Luke's Hospital</u>				3. NAME OF DECEASED (Type or Print) a. (First) <u>Jesse</u> b. (Middle) <u>James</u> c. (Last) <u>Rickman</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>June 10, 1953</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Mail Carrier</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Postal Service</u>		8. DATE OF BIRTH <u>Dec 13 1893</u>		9. AGE (In years last birthday) <u>59</u> <small> <input type="checkbox"/> UNDER 1 YEAR <input type="checkbox"/> UNDER 1 MONTH <input type="checkbox"/> UNDER 1 DAY <input type="checkbox"/> UNDER 1 HOUR <input type="checkbox"/> UNDER 1 MIN. </small>	
11. BIRTHPLACE (State or foreign country) <u>Washington County, Mo</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13a. FATHER'S NAME <u>Unknown Rickman</u>			
13b. MOTHER'S MAIDEN NAME <u>Unknown</u>		14. NAME OF HUSBAND OR WIFE <u>Bessie Rickman</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT'S SIGNATURE OR NAME <u>Mrs. Bessie Rickman, Bismarck, Mo.</u> ADDRESS _____			
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) <u>Coronary thrombosis</u>				INTERVAL BETWEEN ONSET AND DEATH <u>4 days</u>			
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. <u>Chronic glomerulo nephritis</u>			
19a. DATE OF OPERATION _____		19b. MAJOR FINDINGS OF OPERATION _____		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
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) _____		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? <u>4201</u>			
22. I hereby certify that I attended the deceased from <u>6-8</u> , 19 <u>53</u> , to <u>6-10</u> , 19 <u>53</u> , that I last saw the deceased alive on <u>6-10</u> , 19 <u>53</u> , and that death occurred at <u>9:0 P</u> m., from the causes and on the date stated above.							
23a. SIGNATURE <u>Leo W. Stuer</u> (Degree or title) <u>M.D.</u>				23b. ADDRESS <u>3720 Washington Blvd.</u>		23c. DATE SIGNED <u>6-11-53</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		24b. DATE <u>6-13-53</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Masonic</u>		24d. LOCATION (City, town, or county) (State) <u>Bismarck, Missouri</u>	
DATE REC'D BY LOCAL REG. <u>JUN 13 1953</u>		REGISTRAR'S SIGNATURE <u>J. Earl Smith M.D. x P</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Albert H. Hoppe</u> ADDRESS <u>4700 Washington</u>			

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.....

.....
working under my personal supervision.

Student Embalmer No.....

Signed.....

John J. James

Signed.....
Student Embalmer

Licensed Embalmer No. 4108

P. O. Address Albany, N.Y.

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.