

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-030897

STATE FILE NUMBER

7619

FILED AUG 28 1958 Registration District No. 318 Primary Registration District No. 1003 Registrar's No.

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Illinois b. COUNTY Sangamon	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN ST. LOUIS, MISSOURI		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN Springfield 8/208
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 04 BARNES HOSPITAL		Length of stay in 1b 0	d. STREET ADDRESS (If outside, give location) 32 1055 N. Wheeler
Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			

3. NAME OF DECEASED (Type or print) First Middle Last JOSEPH L. RICKARD			4. DATE OF DEATH Month Day Year AUGUST 3, 1958		
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5. SEX Male 0	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 5, 1906	9. AGE (In years birthday) 51	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Truck Driver Knauts Truck Lines	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) Firm, North Dakota 1	12. CITIZEN OF WHAT COUNTRY? U.S.A.
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13a. FATHER'S NAME Dennis Adam Rickard	13b. MOTHER'S MAIDEN NAME Lena Marie Aune	14. NAME OF HUSBAND OR WIFE Hazel
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15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes or unknown) (If give war or dates of service) No. 11.	16. SOCIAL SECURITY NO. 334-12-0270	17. INFORMANT Address Mrs. Hazel Rickard 1055 No. Wheeler, Springfield, Illinois.
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) MALIGNANT TUMORS OF BRAIN (GLIOBLASTOMA AND QUESTIONABLE MENINGIOMA)		INTERVAL BETWEEN ONSET AND DEATH 1 YEAR
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b)	193.0
	DUE TO (c)	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>

20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)	
20c. TIME OF INJURY Hour Month, Day, Year a.m. p.m.		
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION COUNTY STATE

21. I attended the deceased from JULY 18, 1958, to AUG. 3, 1958 and last saw her alive on AUG. 3, 1958
Death occurred at 7:45 A.M. m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Name or title) <i>J. Carl Smith</i> M. D.	22b. ADDRESS BARNES HOSPITAL	22c. DATE SIGNED 8/3/58
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23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE 8-5-58	23c. NAME OF CEMETERY OR CREMATORY Mt. Auburn Cemetery	23d. LOCATION (City, town, or county) (State) Colchester, Illinois.
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24. FUNERAL DIRECTOR Albert H. Hoppe 4700 Washington, Blvd.	25. DATE RECD. BY LOCAL REG. AUG 6 '58	26. REGISTRAR'S SIGNATURE <i>J. Carl Smith, M.D.</i> m. J.B.
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Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE
MEDICAL CERTIFICATION

S. 300
v. 1-57

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, Student Embalmer No. working under my personal supervision.

Student
Signature of Student Embalmer

Signed *Stanley H. DeFord*

Licensed Embalmer No. *4193*
P. O. Address *St. Louis, 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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.