

Health,
Welfare
Public
Service

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-002565

STATE FILE NUMBER

FILED FEB 9 1959

Registration District No. 310 Primary Registration District No. 3058 Registrar's No. 28

300
1-57

1. PLACE OF DEATH a. COUNTY St Charles		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY St Charles	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St Charles Mo	Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN St Charles	0920 0 Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION St Joseph Hospital		Length of stay in 1b 2 days	d. STREET ADDRESS (If outside, give location) Rt 3 Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First Middle Last Ira E Bricker	4. DATE OF DEATH Month Day Year Feb. 2 1959
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5. SEX Male	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 Feb. 17 1903	9. AGE (In years Last birthday) 55	IF UNDER 1 YEAR Months Days	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) Harbor Master	10b. KIND OF BUSINESS OR INDUSTRY Port Harbor	11. BIRTHPLACE (City and state or country) St Charles Mo	12. CITIZEN OF WHAT COUNTRY? USA
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13a. FATHER'S NAME John Bricker	13b. MOTHER'S MAIDEN NAME Elizabeth Tillotson	14. NAME OF HUSBAND OR WIFE Helen Studer Bricker
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15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No	16. SOCIAL SECURITY NO. 497-01-5513	17. INFORMANT Mrs Helen Bricker	Address St Charles Mo
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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) <u>bronchogenic carcinoma</u> <u>to metastases</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) _____ DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH <u>1 year?</u> <u>6 mrs?</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>16 2 1</u>		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.)
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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
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21. I attended the deceased from Death occurred at <u>12/24-58</u> to <u>2-2-59</u> and last saw ^{her} him alive on <u>2-2-59</u> <u>5:30 PM</u> m on the date stated above; and to the best of my knowledge, from the causes stated.
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22a. SIGNATURE <u>George E Kuster</u> (Degree or title) <u>MD</u>	22b. ADDRESS <u>St Charles Mo</u>	22c. DATE SIGNED <u>2-5-59</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>Feb. 5 1959</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Oak Grove Cemetery</u>	23d. LOCATION (City, town, or county) (State) <u>St Charles Mo</u>
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24. FUNERAL DIRECTOR <u>Arthur C Bauc</u>	ADDRESS <u>St Charles Mo.</u>	25. DATE RECD. BY LOCAL REG. <u>FEB 4-59</u>	26. REGISTRAR'S SIGNATURE <u>Marcella Wilson</u>
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USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

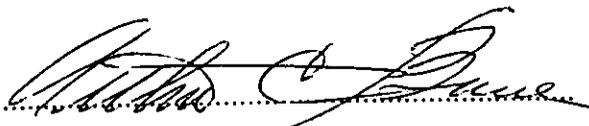
All diseases in Part I must be causally related.

APR 16 1969

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 

Licensed Embalmer No. 3151

P. O. Address St. Charles

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.