

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-015606

STATE FILE NUMBER

2 3851

FILED MAY 8 1959

Registration District No.

Primary Registration District No.

Registration No.

300

-57

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1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before)	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN Jennings 4138
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Christian Hosp.		Length of stay in lb 5 Minutes	d. STREET ADDRESS (If outside, give location) 8334 Willett
			Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print)			4. DATE OF DEATH	
First Peter	Middle	Last Rickard	Month April	Day 17
5. SEX male		6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH Feb 5, 1872		9. AGE (In years last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. 87 Months Days Hours Min.		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) labor	10b. KIND OF BUSINESS OR INDUSTRY General	11. BIRTHPLACE (City and state or country) St. Louis Co., Mo.	12. CITIZEN OF WHAT COUNTRY? U.S.A.
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13a. FATHER'S NAME Solomon Rickard	13b. MOTHER'S MAIDEN NAME Elizia Gardner	14. NAME OF HUSBAND OR WIFE Sarah Landing
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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. no	17. INFORMANT Mrs. Albert Hohmann	Address Jennings Mo 8334 Willett
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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) Broncho-pneumonia		INTERVAL BETWEEN ONSET AND DEATH. 3-12-59 597.
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) Chr. Myocarditis	
	DUE TO (c) Chr. Myocarditis	

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) 4222		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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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 a.m. p.m.	20d. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	20e. CITY, TOWN, OR LOCATION	COUNTY	STATE
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21. I attended the deceased from Death occurred at 9:25 PM on the date stated above; and to the best of my knowledge, from the causes stated.	21. I attended the deceased from 2/19/59 to 4/17/59 and last saw her alive on 4/14/59
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22a. SIGNATURE H. S. Pruffett	(Degree or title) M.D.	22b. ADDRESS 744 W. Florissant	22c. DATE SIGNED 4-18-59
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23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE 4-20-59	23c. NAME OF CEMETERY OR CREMATORY Gumbo Cemetery	23d. LOCATION (City, town, or county) (State) Gumbo Mo.
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24. FUNERAL DIRECTOR Schrader Funeral Home Ballwin Mo.	25. DATE RECD. BY LOCAL REG. APR 20 '59	26. REGISTRAR'S SIGNATURE Loan Smith, M.D.
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USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

All diseases in Part I must be causally related.

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 *Richard M. Bopp*

Licensed Embalmer No. *4584*

P. O. Address *Gallwin, 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.