

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-62-043970

STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. 318

Primary Registration District No. 1003

Registrar's No. 10727

FILED DEC 7 1962

VS 300
Rev. 4/59

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

USE BLACK INK OR TYPEWRITER RIBBON

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY		b. CITY (if outside corporate limits, give TOWNSHIP only) St. Louis		Length of stay in 1b	c. CITY OR TOWN St. Louis		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (if NOT in hospital, give location) HOSPITAL OR INSTITUTION D.O.A. City Hospt.				Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS 4250 N. Broadway St.			Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) Robert Harold Bickel			First	Middle	Last	4. DATE OF DEATH 11 5 62		
5. SEX M	6. COLOR OR RACE W	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 2/24/31	9. AGE (last birthday) 31	IF UNDER 1 YEAR Months Days		IF UNDER 24 HR Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unemployed		10b. KIND OF BUSINESS OR INDUSTRY Machine Operator		11. BIRTHPLACE (City and state or country) St. Charles Mo.		12. CITIZEN OF WHAT COUNTRY U.S.		
13a. FATHER'S NAME Frank Bickel			13b. MOTHER'S MAIDEN NAME Sadie Hank			14. NAME OF HUSBAND OR WIFE Linda Bickel		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes Peacetime				17. INFORMANT Mrs. S. Adams 4250 N. Broadway				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hemorrhage into the right thoracic cavity, with pneumothorax on the right side; laceration of right ventricle; following gunshot wound in left chest; suffered when shot with gun in hands of one, James LaRue, in home at 4439a Gravois Ave. about 5:00 P.M. Nov. 5, 1962 DUE TO (b) HOMICIDE DUE TO (c) Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)						PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	20a. ACCIDENT <input type="checkbox"/>	SUICIDE <input type="checkbox"/>	HOMICIDE <input checked="" type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.) 981x (see above)			
20c. TIME OF INJURY 5:00 P.M.		Hour a.m. 11/5/62		20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>				
20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) home			20f. CITY, TOWN, OR LOCATION St. Louis, Missouri					
21. I attended the deceased from _____ to _____ and last saw her/him alive on _____ Death occurred at 6:00 P.M. on the date stated above, and to the best of my knowledge, from the causes stated.								
22a. SIGNATURE <i>Robert D. Kinealy</i>				(Degree or title)		22b. ADDRESS 1300 Clark		22c. DATE SIGNED 11-8-62
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal		23b. DATE 11/9/62	23c. NAME OF CEMETERY OR CREMATORY Memorial Park Cemet.			23d. LOCATION (City, town or county) (State) St. Louis Co.		
24. FUNERAL DIRECTOR Robert D. Kinealy 2228 St. Louis Ave.				ADDRESS		25. DATE RECD. BY LOCAL REG. NOV 8 1962		26. REGISTRAR'S SIGNATURE <i>Loard Smith, M.D.</i>

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 _____
Signature of Student Embalmer

Signed Gustav W. Dietrich

Licensed Embalmer No. 4329

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.