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DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS  
**FILED SEPT 7 1944**  
Registration District No. 139

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. 27850  
Registrar's No. 56

Primary Registration District No. 5530

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH:  
(a) County Holt  
(b) City or town Rural -- Benton Twp.  
(c) Name of hospital or institution: /  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution.....  
In this community.....  
years, months or days

2. USUAL RESIDENCE OF DECEASED:  
(a) State Missouri (b) County Holt.  
(c) City or town Rural.  
(If outside city or town limits, write "RURAL")  
(d) Street No.....  
(If rural, give location)  
(e) Citizen of foreign country? No. (Yes or No)  
If yes, name country.....

3. (a) PRINT FULL NAME Julie Gertrude Brickey.

3. (b) If veteran, name war.....  
3. (c) Social Security No.....

4. Sex Female 5. Color or race White  
6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Winnie Brickey.  
6. (c) Age of husband or wife if alive..... years

7. Birth date of deceased Aug. 13th. 1887.  
(Month) (Day) (Year)

8. AGE: Years 57 Months 0 Days 2  
If less than one day  
hr. min.

9. Birthplace Salem Ind. /  
(City, town, or county) (State or foreign country)

10. Usual occupation House wife.

11. Industry or business.....

MOTHER FATHER { 12. Name Peter Fultz.

13. Birthplace Salem Ind. /  
(City, town, or county) (State or foreign country)

14. Maiden name Martha Overshief.

15. Birthplace Salem Ind. /  
(City, town, or county) (State or foreign country)

16. (a) Informant Mina Jones.

(b) Address St. Joseph. Mo.

17. (a) Burial (b) Date thereof Aug. 17th /  
(Burial, cremation, or removal) (Month) (Day) (Year)  
Maitland Mo.

(c) Place: burial or cremation.....  
18. (a) Signature of funeral director M. Crawford  
(b) Address Mound City. Mo.

19. (a) Aug 17, 1944 (b) Pauline Dawson  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug. day 15th.  
year 1944. hour 6 minute 30 P.M.

21. I hereby certify that I attended the deceased from April 15, 1944, to Aug 15, 1944  
that I last saw her alive on Aug 14, 1944  
and that death occurred on the date and hour stated above.

Immediate cause of death Wide Metastasis from Carcinoma of Cervix  
Duration: 5-year

Due to.....

Other conditions.....  
(Include pregnancy within 3 months of death)

Major findings:  
Of operations.....  
Of autopsy.....  
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify).....

(b) Date of occurrence.....

(c) Where did injury occur?.....  
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place?  
.....

While at work?..... (Specify type of place) (e) Means of injury.....

23. Signature F. C. Flowers (M. D. or other)  
Address Mound City Date signed 8-17-44

**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.....  
....., Registered Apprentice No.....  
working under my personal supervision.

Signed

*J. H. Crawford*

Licensed Embalmer No.

*1874*

P. O. Address

*Grand City, 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 this body is not embalmed, fact should be so stated above.**