

DEPARTMENT OF COMMERCE THE STATE BOARD OF HEALTH OF MISSOURI  
FILED AUG 27 1946 STANDARD CERTIFICATE OF DEATH

State File No. \_\_\_\_\_

Registration District No. 53

Primary Registration District No. 3010

Registrar's No. 278

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD  
16  
1  
4  
25335

1. PLACE OF DEATH:

(a) County Cape Girardeau

(b) City or town Cape Girardeau  
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: St Francis Hosp't  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution one day  
(Specify whether years, months or days) Life

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Scott Co

(c) City or town Oran Mo 4  
(If outside city or town limits, write "RURAL") 0

(d) Street No. \_\_\_\_\_ (If rural, give location) 1

(e) Citizen of foreign country?  (Yes or No)

If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME TERRY LEON BICKINGS

3. (b) If veteran, name war

3. (c) Social Security No.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug day 13<sup>th</sup>  
year 1946 hour 11 minute 25 a. M.

4. Sex Male 5. Color or race wh.

6. (a) Single, widowed, married, divorced  0

6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_ years  
(Day) (Year)

7. Birth date of deceased Dec 25 1944  
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from Aug 12 1946 to Aug 13 1946  
that I last saw him alive on Aug 13 1946  
and that death occurred on the date and hour stated above.

8. AGE:	Years	Months	Days	If less than one day
	<u>1</u>	<u>7</u>	<u>18</u>	hr. _____ min. <u>0</u>

Immediate cause of death Ruptured gangrenous appendix with peritonitis 4 days  
Duration

9. Birthplace Oran R.F.D. (City, town, or county) (State or foreign country)

10. Usual occupation Child

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions (Include pregnancy within 3 months of death) \_\_\_\_\_

11. Industry or business \_\_\_\_\_

12. Name Fred. D. Becking

13. Birthplace Huley Miss (City, town, or county) (State or foreign country)

14. Maiden name Stacy Griswell

15. Birthplace Mo Nairy Pond (City, town, or county) (State or foreign country)

Major findings: Of operations as above 12/12

Of autopsy \_\_\_\_\_

PHYSICIAN \_\_\_\_\_  
Underline the cause to which death should be charged statistically.

16. (a) Informant Father

(b) Address Oran Mo

17. (a) Burial (b) Date thereof 8 15 1946  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Oran Mo

18. (a) Signature of funeral director Heisserer Fun Home

(b) Address Oran Mo

19. (a) 8-22-1946 C. C. Summers  
(Date received local registrar) (Registrar's signature)

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 0

23. Signature R. G. Ritter, M.D. (M. D. or other)  
Address Cape Girardeau Mo Date signed Aug 27 1946

RECEIVED

Health Officer No. 4  
District File Number 846-2524  
Date Filed 8-26-46

---

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 Raymond Crews

Licensed Embalmer No. 3467

P. O. Address Sikeston 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.