

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **34540**

FILED NOV 2 1949

73  
7

|  |  |   |  |  |   |  |   |  |
|--|--|---|--|--|---|--|---|--|
| BIRTH NO. _____  |  | REG. DIST. NO. <b>248</b>   |  | PRIMARY REG. DIST. NO. <b>4369</b>   |   | Registrar's No. <b>20</b>  |   |  |
| 1. PLACE OF DEATH<br>a. COUNTY <b>Newton</b>   |  |   |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: residence before death.)<br>a. STATE <b>Missouri</b> b. COUNTY <b>Newton</b> |   |  |   |  |
| b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>Seneca</b>   |  | c. LENGTH OF STAY (in this place) <b>10 yrs</b>   |  | c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>Seneca</b>   |   | 78   |   |  |
| d. FULL NAME OF HOSPITAL OR INSTITUTION  |  |   |  | d. STREET ADDRESS (If rural, give location)  |   |  |   |  |
| 3. NAME OF DECEASED (Type or Print)<br>a. (First) <b>William</b> b. (Middle) <b>Alfred</b> c. (Last) <b>Bricker</b>  |  |   | 4. DATE OF DEATH (Month) (Day) (Year)<br><b>Oct. 23 1949</b> |  |   |  |   |  |
| 5. SEX <b>Male</b>   |  | 6. COLOR OR RACE <b>white</b>   |  | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>widowed</b>  |   | 8. DATE OF BIRTH <b>Jan. 14, 1865</b>                            |   |  |
| 9. AGE (In years last birthday) <b>84</b>  |  | IF UNDER 1 YEAR Months  |  | IF UNDER 1 YEAR Days   |   | IF UNDER 1 HRS. Hours Min.                                       |   |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Merchant</b>  |  |   | 10b. KIND OF BUSINESS OR INDUSTRY <b>Retired</b>             |  | 11. BIRTHPLACE (State or foreign country) <b>Ohio</b> |  | 12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>  |  |
| 13a. FATHER'S NAME <b>R. A. Bricker</b>  |  |   | 13b. MOTHER'S MAIDEN NAME <b>No Known</b>                    |  |   | 14. NAME OF HUSBAND OR WIFE <b>Frances</b>                       |   |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no</b>   |  | 16. SOCIAL SECURITY NO.   |  | 17. INFORMANT'S SIGNATURE OR NAME ADDRESS  |   |  |   |  |
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)<br><br>*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.                                   |  | MEDICAL CERTIFICATION<br>I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Coronary Occlusion</b><br><br>ANTECEDENT CAUSES<br>Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.<br>DUE TO (b) _____<br>DUE TO (c) _____<br><br>II. OTHER SIGNIFICANT CONDITIONS<br>Conditions contributing to the death but not related to the disease or condition causing death. |  |  |   |  | INTERVAL BETWEEN ONSET AND DEATH<br><br><br><br><br><br><br><br><br><br><b>4:30</b> |  |
| 19a. DATE OF OPERATION   |  | 19b. MAJOR FINDINGS OF OPERATION  |  |  |   |  | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>            |  |
| 21a. ACCIDENT SUICIDE HOMICIDE (Specify)   |  | 21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)  |  | 21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)  |   |  |   |  |
| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)   |  | 21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21f. HOW DID INJURY OCCUR?   |   |  |   |  |
| 22. I hereby certify that I attended the deceased from <b>Oct 23, 1949</b> , to <b>Oct 23, 1949</b> , that I last saw the deceased alive on <b>Oct 23, 1949</b> , and that death occurred at <b>4:50 P. M.</b> , from the causes and on the date stated above. |  |   |  |  |   |  |   |  |
| 23a. SIGNATURE (Degree or title) <b>W. B. Swenler M.D.</b>   |  |   |  | 23b. ADDRESS <b>Seneca Mo.</b>   |   | 23c. DATE SIGNED <b>10-26-49</b>                                 |   |  |
| 24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>  |  | 24b. DATE   |  | 24c. NAME OF CEMETERY OR CREMATORY <b>Seneca Cemetery</b>  |   | 24d. LOCATION (City, town, or county) (State) <b>Seneca, Mo.</b> |   |  |
| DATE REC'D BY LOCAL REG. <b>Oct 26, '49</b>  |  | REGISTRAR'S SIGNATURE <b>Phyllis Brite</b>  |  | 25. FUNERAL DIRECTOR'S SIGNATURE <b>W. E. Beddlesome</b>   |   | ADDRESS <b>Seneca Mo</b>   |   |  |

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

# RECEIVED

District Health Officer No. NEWTON

District File Number 1049-202

Date Filed OCT 31 1949

CO. HEALTH DEPT.

NOV 8 1949

## 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 \_\_\_\_\_  
Student Embalmer

Signed W E Biddlecome

Licensed Embalmer No. 2174

P. O. Address Seneca 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.