

FILED OCT 1 1951

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **29958**

BIRTH NO. _____ REG. DIST. NO. **128** PRIMARY REG. DIST. NO. **2000** Registrar's No. **807**

1. PLACE OF DEATH a. COUNTY GREENE		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Missouri b. COUNTY Christian	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Springfield		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Chadwick, Rural	
c. LENGTH OF STAY (in this place) 1 Day		d. STREET ADDRESS (If rural, give location) Rural	
d. FULL NAME OF HOSPITAL OR INSTITUTION OZARK OSTEOPATHIC HOSPITAL			
3. NAME OF DECEASED a. (First) William b. (Middle) Riley c. (Last) Bricker			4. DATE OF DEATH (Month) (Day) (Year) 9/19/51
5. SEX Male	6. COLOR OR RACE WHITE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Single	8. DATE OF BIRTH 5/30/1878
9. AGE (in years last birthday) 73		10. MONTHS 3 DAYS 18 HOURS MIN. 	
10a. USUAL OCCUPATION (Of his kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY Farming	
11. BIRTHPLACE (State or foreign country) Christian County, Mo.		12. CITIZEN OF WHAT COUNTRY? U. S.	
13a. FATHER'S NAME Jacob Bricker		13b. MOTHER'S MAIDEN NAME Mary Sidal	
14. NAME OF HUSBAND OR WIFE None			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) No (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT'S SIGNATURE OR NAME Mrs. Nancy Ellingsworth, Chadwick ADDRESS Chadwick			
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, ashenia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Toxemia ANTECEDENT CAUSES DUE TO (b) Bowel Obstruction DUE TO (c) Metastatic carcinoma of the Liver II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		156 B	
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) 156 B			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		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 9/18 , 19 51 , to 9/19 , 19 51 , that I last saw the deceased alive on 9/19 , 19 51 , and that death occurred at 3:40 P.M. , from the causes and on the date stated above.			
23a. SIGNATURE William P. Mitchell M.D. (Degree or title) M.D.		23b. ADDRESS Springfield, Mo.	
23c. DATE SIGNED Sept 19-1951			
24a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		24b. DATE SEPT. 22-1951	
24c. NAME OF CEMETERY OR CREMATORY GARRISON		24d. LOCATION (City, town, or county) (State) GARRISON MO.	
DATE REC'D BY LOCAL REG. 9-25-51		REGISTRAR'S SIGNATURE W.E. Landley	
25. FUNERAL DIRECTOR'S SIGNATURE John Dean Harris		ADDRESS Claver, Mo.	

(Licensed Embalmer's Statement on Reverse Side)

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

0396

0

651

1924

6/12/24

STATE OF MISSOURI

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.....

John Dean Harris

Licensed Embalmer No. 4390

P. O. Address Cleveland, 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.