

THE DIVISION OF HEALTH OF MISSOURI
 STANDARD CERTIFICATE OF DEATH

32744

State File No. _____

FILED SEP 25 1952

BIRTH NO. _____ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003** Registrar's No. **8236**

1. PLACE OF DEATH a. COUNTY St. Louis		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY St. Louis	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis		c. LENGTH OF STAY (In this place) 2 mos. & 8 days	
c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis		d. STREET ADDRESS (If rural, give location) 508 Chestnut	
d. FULL NAME OF HOSPITAL OR INSTITUTION City Infirmary Hospital		e. DATE OF DEATH (Month) (Day) (Year) 8 28 1952	
3. NAME OF DECEASED (Type or Print) a. (First) CARRINGTON b. (Middle) _____ c. (Last) BICKERS		4. DATE OF DEATH (Month) (Day) (Year) 8 28 1952	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widower	8. DATE OF BIRTH 12/5/1882
9. AGE (In years last birthday) 69		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none	
10b. KIND OF BUSINESS OR INDUSTRY _____		11. BIRTHPLACE (City and State or Foreign Country) Virginia	
12. CITIZEN OF WHAT COUNTRY? U.S.		13a. FATHER'S NAME James Bickers	
13b. MOTHER'S MAIDEN NAME Fitzpatrick, Mary		14. NAME OF HUSBAND OR WIFE Widower	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) _____		16. SOCIAL SECURITY NO. _____	
17. INFORMANT'S SIGNATURE OR NAME City Infirmary -		ADDRESS 5800 Arsenal St.	
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, asthma, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Myocardial infarction ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____ 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"/>		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) _____		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
21f. HOW DID INJURY OCCUR? 4201		22. I hereby certify that I attended the deceased from 6/20 , 19 52 , to 8/28 , 19 52 , that I last saw the deceased alive on 8/28 , 19 52 , and that death occurred at 2:20 P.m. , from the causes and on the date stated above.	
23a. SIGNATURE (Degree or title) William M. Hines MD		23b. ADDRESS 5600 Arsenal St.	
23c. DATE SIGNED 8/28/52		24a. BURIAL, CREMATION, REMOVAL (Specify) Cremation	
24b. DATE 9-3-52		24c. NAME OF CEMETERY OR CREMATORY City Crematory	
24d. LOCATION (City, town, or county) (State) St. Louis, Mo.		25. FUNERAL DIRECTOR'S SIGNATURE J. Ryan	
25. ADDRESS 5600 Arsenal St.		DATE REC'D BY LOCAL REG. SEP 2 1952	

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

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. J. Embalmel

Licensed Embalmer No. _____
P. O. Address _____

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.