

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **43809**

FILED DEC 15 1953

BIRTH NO. _____ REG. DIST. NO. **273** PRIMARY REG. DIST. NO. **3051** Registrar's No. **117**

1. PLACE OF DEATH a. COUNTY Perry			2. USUAL RESIDENCE (Where deceased lived; If institution: residence before admission) a. STATE Missouri b. COUNTY Perry		
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Perryville Mo.		c. LENGTH OF STAY (In this place) 12 Days	c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Rural Cinque Homme		
d. FULL NAME OF HOSPITAL OR INSTITUTION Perry Co. Memorial Hospital			d. STREET ADDRESS (If rural, give location) 0790		

3. NAME OF DECEASED (Type or Print) a. (First) Ferd b. (Middle) R. c. (Last) Brickhaus			4. DATE OF DEATH (Month) (Day) (Year) Nov. 29 1953		
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5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH Nov. 20 1890		9. AGE (In years last birthday) 63	IF UNDER 1 YEAR Months 0 Days 0	IF UNDER 4 HRS. Hours 0 Min. 0
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Perry Co. Mo.		12. CITIZEN OF WHAT COUNTRY? U.S.A.
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13a. FATHER'S NAME Fritz Brickhaus		13b. MOTHER'S MAIDEN NAME Louisa Lovis		14. NAME OF HUSBAND OR WIFE Helen Brickhaus	
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes, give war or dates of service) World war I		16. SOCIAL SECURITY NO. None	17. INFORMANT'S SIGNATURE OR NAME Raymond Brickhaus Biehle ADDRESS Star R M		
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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) Malignant melanoma				INTERVAL BETWEEN ONSET AND DEATH 2 yrs.
	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 190x			20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
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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)	
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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?	
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22. I hereby certify that I attended the deceased from **18 Nov, 1953** to **29 Nov, 1953**, that I last saw the deceased alive on **29 Nov, 1953**, and that death occurred at **10:45 AM**, from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) J. Grayson, M.D.		23b. ADDRESS Perryville, Mo.		23c. DATE SIGNED DEC 4 1953	
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24a. BURIAL CREMATION, REMOVAL (Specify) Burial	24b. DATE Dec. 1 1953	24c. NAME OF CEMETERY OR CREMATORY Lutheran Cemetery	24d. LOCATION (City, town, or county) (State) Perryville Mo.		
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DATE REC'D BY LOCAL REG. 12-1-53	REGISTRAR'S SIGNATURE Joseph Joellner 250-		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Young & Sons Perryville Mo		
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

DEC 1

JAN 26 1959

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

working under my personal supervision.

Student Embalmer No.....

Signed.....
Student Embalmer

Signed *Wallace Young*

Licensed Embalmer No. *4027*

P. O. Address *Perquimans*

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.