

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

209

STATE FILE NUMBER

FILED JAN 28 1957

Registration District No. 38 Primary Registration District No. 3006 Registrar's No. 38

|   |  |   |  |   |  |   |  |
|---|--|---|--|---|--|---|--|
| 1. PLACE OF DEATH   |  |   |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)     |  |   |  |
| a. COUNTY <u>Boone</u>  |  | b. CITY (If outside corporate limits, give TOWNSHIP only)<br>OR<br>TOWN <u>Columbia</u> |  | a. STATE <u>Missouri</u>  |  | b. COUNTY <u>Gasconade</u>  |  |
| c. FULL NAME OF HOSPITAL OR INSTITUTION <u>Cancer Hospital</u>  |  | Inside Limits<br>Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>    |  | c. CITY OR TOWN <u>Hermann</u>  |  | Inside Limits<br>Yes <input type="checkbox"/> No <input type="checkbox"/>                         |  |
| d. STREET ADDRESS   |  | Length of stay in lb <u>45 days</u>   |  | (If outside, give location)   |  | Reside on Farm<br>Yes <input type="checkbox"/> No <input type="checkbox"/>                        |  |
| 3. NAME OF DECEASED (Type or print)   |  |   |  | 4. DATE OF DEATH  |  | 5. AGE (In years last birthday)   |  |
| First <u>Otto Fredrick</u>  |  | Middle <u>Bickmeyer</u>   |  | Last <u>Bickmeyer</u>   |  | Month <u>1</u> Day <u>24</u> Year <u>57</u>   |  |
| 6. COLOR OR RACE <u>W</u>   |  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>              |  | 8. DATE OF BIRTH <u>7-28-89</u>   |  | 9. AGE (In years last birthday) <u>67</u>   |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>Chiropractor</u>  |  | 10b. KIND OF BUSINESS OR INDUSTRY<br><u>None</u>  |  | 11. BIRTHPLACE (City and state or country)<br><u>Gasconade Co, Mo</u>                     |  | 12. CITIZEN OF WHAT COUNTRY?<br><u>U.S.A.</u>   |  |
| 13. FATHER'S NAME<br><u>Otto Bickmeyer</u>  |  |   |  | 14. MOTHER'S MAIDEN NAME<br><u>Louise Toedtman</u>  |  |   |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)<br><u>Unknown</u>   |  | 16. SOCIAL SECURITY NO. <u>494-10-0458</u>  |  | 17. INFORMANT Address<br><u>Hospital records, Highway 40</u>                              |  |   |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Lymphosarcoma, generalized</u>  |  |   |  |   |  | INTERVAL BETWEEN ONSET AND DEATH<br><u>1 year</u>   |  |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) _____   |  |   |  |   |  |   |  |
| DUE TO (c) _____  |  |   |  |   |  |   |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)   |  |   |  |   |  | 19. WAS AUTOPSY PERFORMED?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 20a. ACCIDENT <input type="checkbox"/>  |  | SUICIDE <input type="checkbox"/>  |  | HOMICIDE <input type="checkbox"/>   |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)      |  |
| 20c. TIME OF INJURY   |  | Hour _____  |  | Month, Day, Year _____  |  |   |  |
| 20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/>   |  | NOT WHILE AT WORK <input type="checkbox"/>  |  | 20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) |  | 20f. CITY, TOWN, OR LOCATION COUNTY STATE   |  |
| 21. I attended the deceased from <u>12-10-56</u> to <u>1-24-57</u> and last saw <sup>her</sup> alive on <u>1-24-57</u><br>Death occurred at <u>4:10</u> p. m on the date stated above; and to the best of my knowledge, from the causes stated. |  |   |  |   |  |   |  |
| 22a. SIGNATURE (Degree or title)<br><u>Catrick W. Butler M.D.</u>   |  |   |  | 22b. ADDRESS<br><u>STATE CANCER HOSPITAL</u>  |  | 22c. DATE SIGNED<br><u>1-24-57</u>  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)   |  | 23b. DATE<br><u>Jan 25 1957</u>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><u>Hermann</u>                                      |  | 23d. LOCATION (City, town, or county) (State)<br><u>Mo.</u>                                       |  |
| 24. FUNERAL DIRECTOR ADDRESS<br><u>Hugo H. Plouffe Hermann, Mo</u>  |  |   |  | 25. DATE RECD. BY LOCAL REG.<br><u>Jan 25 1957</u>  |  | 26. REGISTRAR'S SIGNATURE<br><u>Mrs R.E. Palmer</u>   |  |

diseases in Part I must be casually related. Coroner cannot certify to a death due to natural causes. USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

(Licensed Embalmer's Statement on Reverse Side)

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.....  
Signature of Student Embalmer

Signed *Chas. N. Pope*.....

Licensed Embalmer No. *258*

P. O. Address *Herman*.....

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (to comply with the above constitutes grounds for revocation of license).  
If embalmed by a STUDENT, he also shall sign in his OWN handwriting.  
If this body is not embalmed, fact should be so stated above.