

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-016640

FILED VS MAY 2 1960

2 4301

STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis		c. CITY OR TOWN St. Louis	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Deaconess		d. STREET ADDRESS (If outside, give location) #40 North Kingshighway	
3. NAME OF DECEASED (Type or print) First Emma Middle Louise Last Brickenkamp		4. DATE OF DEATH Month April Day 19th Year 1960	
5. SEX Female	6. COLOR OR RACE White	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 3/31/1878
9. AGE (last birthday) 82		IF UNDER 1 YEAR Months 0 Days 18	IF UNDER 24 HR Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) At Home		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) St. Louis, Mo.
12. CITIZEN OF WHAT COUNTRY USA		13a. FATHER'S NAME Will Brickenkamp	13b. MOTHER'S MAIDEN NAME Anna Schluer
14. NAME OF HUSBAND OR WIFE		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No	16. SOCIAL SECURITY NO. No
17. INFORMANT Mrs Robert Porter #18 Lake Forest		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. IMMEDIATE CAUSE (a) Cerebral Thrombosis DUE TO (b) Hypertensive Cardiovascular Disease DUE TO (c) 443 & F			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease/condition given in PART I (a) Fracture of right femur.			PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20a. ACCIDENT <input checked="" 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.) Fell on ice in front of home.	
20c. TIME OF INJURY Hour 11:00 p.m. Month, Day, Year 11 26 59			
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) 12 Home	20f. CITY, TOWN, OR LOCATION St. Louis
20g. COUNTY Mo.		20h. STATE Mo.	
21. I attended the deceased from 3:30 5/1/48 to 4/17/60 and last saw her 4/18/60 Death occurred at a m on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE Hugo F. Bergman M.D.		22b. ADDRESS 3720 Washington	
22c. DATE SIGNED 4/21/60		(State)	
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE 4/21/1960	23c. NAME OF CEMETERY OR CREMATORY Oak Grove Mausoleum	23d. LOCATION (City, town, or county) St Louis County MO
24. FUNERAL DIRECTOR Ambruster Mortuary 6633 Clayton Rd		25. DATE RECD. BY LOCAL REG. APR 21 1960	26. REGISTRAR'S SIGNATURE Carl Smith. M.D.

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

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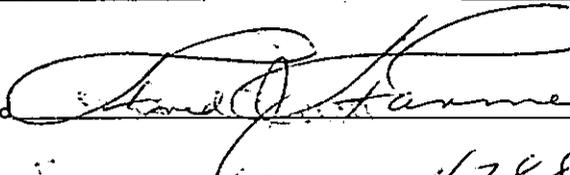
STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by
or by _____ Student Embalmer No. _____
working under my personal supervision.

Student _____

Signature of Student Embalmer

Signed



Licensed Embalmer No. 4788

P. O. Address St. Louis.

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.