

MISSOURI DIVISION OF PUBLIC HEALTH - STANDARD CERTIFICATE OF DEATH

-61-039122

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

AMENDED

Registration District No. **318** Primary Registration District No. **1003** Registrar's No. **9623**

STATE FILE NUMBER

FILED OCT 26 1961

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) St. Louis			Length of stay in 1b		c. CITY OR TOWN St. Louis		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF HOSPITAL OR INSTITUTION Homer G. Phillips			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) 4554 St. Ferdinand		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Easter Middle Last Rickmon				4. DATE OF DEATH Month 10 Day 16 Year 61			
5. SEX Female	6. COLOR OR RACE Negro	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 6-14-1919	9. AGE (last birthday) 42	IF UNDER 1 YEAR Months	IF UNDER 24 HR Days	IF UNDER 24 HR Hours
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife			10b. KIND OF BUSINESS OR INDUSTRY home		11. BIRTHPLACE (City and state or country) Stovall, Mississippi		12. CITIZEN OF WHAT COUNTRY U.S.A
13a. FATHER'S NAME B.D.Walker			13b. MOTHER'S MAIDEN NAME Nina Morgan		14. NAME OF HUSBAND OR WIFE S.R.Rickmon		
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. Unk.		17. INFORMANT S.R.Rickmon 4554 St. Ferdinand Ave			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage							INTERVAL BETWEEN ONSET AND DEATH Undet.
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.			DUE TO (b) Ruptured Berry Aneurysm		Undet.		
			DUE TO (c) Hypertension		3:30 P.M. Undet.		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)					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 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 a.m. p.m.		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 10-3-61 to 10-16-61 and last saw her alive on 10-16-61 Death occurred at 9:00 p.m. on the date stated above, and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE <i>Char. A. Forde, M.D.</i>			(Degree or title)		22b. ADDRESS 2901 N. Whittier St.		22c. DATE SIGNED 10-17-61
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE 10/20/61	23c. NAME OF CEMETERY OR CREMATORY Washington Park Cemetery		23d. LOCATION (City, town, or county) Berkeley City Missouri		(State)	
24. FUNERAL DIRECTOR C.W.Roberts Und.Co 1416 N.Taylor Ave				25. DATE RECD. BY LOCAL REG. OCT 18 1961		26. REGISTRAR'S SIGNATURE <i>Loan Smith, M.D.</i>	

DATE AMENDED

INSTEAD OF

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

ITEM NO. SHOULD READ

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 James A. Carter

Licensed Embalmer No. 4657

P. O. Address St. Louis, 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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.