DEPARTMENT OF COMMERCE
Bureau of Vital Statistics

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 33413

Registration District No. 33 — Primary Registration District No. 1-02 X 43 — Registrar's No.

1. PLACE OF DEATH:
(a) County St. Francois County
(b) City or town Desloge — Rural
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution (Specify whether years, months or days) In this community

2. USUAL RESIDENCE OF DECEASED:
(a) State Mo (b) County St Francois
(c) City or town Desloge
(If outside city or town limits, write "RURAL")
(d) Street No. —
(If rural, give location)
(e) If foreign born, how long in U. S. A.? — years

3. (a) PRINT FULL NAME Myrah E Rickard

3. (b) If veteran, name war — **3. (c) Social Security No.**

4. Sex Female — **5. Color or race** White — **6. (a) Single, widowed, married, divorced** Widowed

6. (b) Name of husband or wife William Rickard — **6. (c) Age of husband or wife if alive** No years

7. Birth date of deceased Jan. (Month) 20 (Day) 1853 (Year)

8. AGE: Years 86 | Months 8 | Days 4 | If less than one day ___ hr. ___ min.

9. Birthplace Farmington (City, town, or county) MO (State or foreign country)

10. Usual occupation House Work

11. Industry or business —

MOTHER FATHER
12. Name William Grason
13. Birthplace N. Carolina (City, town, or county) (State or foreign country)
14. Maiden name Sarah Hauser
15. Birthplace N. Carolina (City, town, or county) (State or foreign country)

16. (a) Informant's own signature Bessie King
(b) Address Desloge Mo

17. (a) ___ (Burial, cremation, or removal) **(b) Date thereof** Sept 26-39 (Month) (Day) (Year)
(c) Place: burial or cremation Parkview

18. (a) Signature of funeral director C. E. Bayer
(b) Address Desloge Mo

19. (a) 10-9-39 (Date received by local registrar) **(b)** W. D. Duckworth (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept day 24
year 1939 hour 6-30 minute A M.

21. I hereby certify that I attended the deceased from 9/20, 1939, to 9/24 39, 19___; that I last saw h alive on 9/23 1939, 19___; and that death occurred on the date and hour stated above.

Cause of death	Duration
Immediate cause of death Uremia	
from Prostatic Hypertrophy	
Chronic Colitis	1 yr
Due to	
Due to	
Other conditions (Include pregnancy within 3 months of death)	

Major findings:
Of operations —
Of autopsy —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify) —
(b) Date of occurrence —
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place?
While at work? (Specify type of place) (e) Means of injury —

23. Signature W. D. Duckworth (M. D. or other)
Address Desloge Mo Date signed 9/25/39

(Licensed Embalmer's Statement on Reverse Side)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

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.....

....., Registered Apprentice No.....

working under my personal supervision.

Signed C. Z. Baxter

Licensed Embalmer No. 1671

P. O. Address.....

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply wi the above constitutes grounds for revocation of license.)

If this body is not embalmed, above space should be left blank.