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.

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

1 PLACE OF DEATH

County .....

Township ..... or Village ..... or City St Louis Mo (NO. 4476 West Pine Str, St.; 25 Ward)

Registration District No. 791 File No. 30608

Primary Registration District No. 1003 Registered No. 8504

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME Col Horatio Gates Sickles

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Mal

4 COLOR OR RACE White

5 SINGLE MARRIED WIDOWED OR DIVORCED (Write the word) Married

6 DATE OF BIRTH January (Month) 15 (Day), 1854 (Year)

7 AGE 64 yrs. 7 mos. 24 ds. If LESS than 1 day, ... hrs. or ..... min.?

8 OCCUPATION (a) Trade, profession, or particular kind of work U S Army

(b) General nature of industry business, or establishment in which employed (or employer) Col

9 BIRTHPLACE (City or town, State or foreign country) Philadelphia Pa.

PARENTS

10 NAME OF FATHER Horatio Gates Sickles

11 BIRTHPLACE OF FATHER (City or town, State or foreign country) Pa.

12 MAIDEN NAME OF MOTHER Eliza Von Gandt

13 BIRTHPLACE OF MOTHER (City or town, State or foreign country) Pa.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mary J. Sickles

(Address) 4476 West Pine Str.

15 Filed [illegible], 191 Max C Starkloff Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Sept (Month) 9th (Day), 1918 (Year)

17 I HEREBY CERTIFY, that I attended deceased from ....., 191....., to ....., 191.....,

that I last saw h..... alive on ....., 191.....

and that death occurred, on the date stated above, at 12-10 P. m.

The CAUSE OF DEATH* was as follows:

Hemorrhage of Brain due to Gunshot Wound Suicide

167 8375

(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) ~~Homicide~~

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) H. W. Fath M. D.

9/10, 1918 (Address) Deputy Coroner

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted if not at place of death? .....

Former or usual residence 4476 West Pine Boul.

19 PLACE OF BURIAL OR REMOVAL Bellefontaine

DATE OF BURIAL Sept 12, 1918

20 UNDERTAKER Wagoner

ADDRESS 3621 Oli

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

1 PLACE OF DEATH

County .....

Township ..... Registration District No. ..... File No. .....
or
Village ..... Primary Registration District No. ..... Registered No. .....
or
City ..... (NO. ....., ... St., ... Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME .....

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 SINGLE MARRIED WIDOWED OR DIVORCED (*Write* the word)

6 DATE OF BIRTH

..... (Month) ..... (Day) ..... 1..... (Year)

7 AGE

.....yrs. .....mos. .....ds.

If LESS than 1 day, ...hrs. or .....min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work .....

(b) General nature of industry business, or establishment in which employed (or employer) .....

9 BIRTHPLACE
(City or town, State or foreign country)

PARENTS

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER
(City or town, State or foreign country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER
(City or town, State or foreign country)

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) .....

(Address) .....

15

Filed ..... 191..... .....
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

..... (Month) ..... (Day) ..... 191..... (Year)

17 I HEREBY CERTIFY, that I attended deceased from ..... 191..... to ..... 191.....

that I last saw h.....alive on: ..... 191.....

and that death occurred, on the date stated above, at .....m.

The CAUSE OF DEATH* was as follows:

.....

.....

.....

..... (Duration) .....yrs. .....mos. .....ds.

CONTRIBUTORY .....
(Secondary)

..... (Duration) .....yrs. .....mos. .....ds.

(Signed) .....M. D.

..... 191..... (Address) .....

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death .....yrs. .....mos. .....ds. In the State .....yrs. .....mos. .....ds.

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL OR REMOVAL | DATE OF BURIAL ..... 191.....

20 UNDERTAKER | ADDRESS

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.