

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

Do not use this space.

1593

1. PLACE OF DEATH

County Jackson
Township Raw
City St. Louis (No. 399)

Registration District No. 1022
Precinct Registration District No. 184

File No. 184
Registered No. 184
Ward

2. FULL NAME

(a) Residence, No. 3415 Holmes St. Ward. 6
(Usual place of abode)

Length of residence in city or town where death occurred yrs. X mos. 14 ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Y 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Married

6A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Edward H. Hicks

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Aug-23/87

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.
49 4 20

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work at home
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN)

(STATE OR COUNTRY)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER (CITY OR TOWN)

(STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)

(STATE OR COUNTRY)

14.

INFORMANT Mr. Edward H. Hicks
(Address) 3415 Holmes

15.

FILED 1-14-29 M. M. Crow
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Jan. 13 1929

17. I HEREBY CERTIFY, that I attended deceased from Dec. 27, 1929, to Jan. 13, 1929, that I last saw him alive on Jan. 13, 1929, and that death occurred, on the date stated above, at 10:30 P.M.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Pneumonia
1223
1273
129
(duration) yrs. mos. ds.
CONTRIBUTORY Intestinal obstruction
(SECONDARY) (duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH? ec.

DID AN OPERATION PRECEDE DEATH? yes DATE OF Dec 28-1929

WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS? Local findings

(Signed) E. R. Miller, M. D.

Address 800 Reels

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL

DATE OF BURIAL

Merwin Mo 1-15-29

20. UNDERTAKER

ADDRESS

Mrs C. L. Foster 184

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.

WHILE IN LINE, WITH UNFADING INK—THIS IS A PERMANENT RECORD

200-0618

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

ALL INFORMATION CALLED
FOR MUST BE WRITTEN ON
THIS SUPPLEMENTARY.

1. PLACE OF DEATH.

County.....
Township.....
City..... (No.....)

Registration District No. 399
Primary Registration District No. 1082

File No.
Registered No. 187
St. Ward)

2. FULL NAME

Mary Hicks

(a) Residence. No. St. Ward.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX F 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) M

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY AND YEAR)

7. AGE YEARS MONTHS DAYS If LESS than 1 day, ... hrs. or min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY)

14.

INFORMANT (Address)

15.

FILED 1/14/29 M. M. Brown REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Jan 13 19 29

17.

I HEREBY CERTIFY, That I attended deceased from 19....., to 19.....

that I last saw h..... alive on....., 19....., and that death occurred, on the date stated above, at..... m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Brucella pneumonia

(duration) yrs. mos. ds.

CONTRIBUTORY (SECONDARY) Intestinal Obstruction

Post-choleraic peritonitis (duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH

DID AN OPERATION PRECEDE DEATH?

WAS THERE AN AUTOPSY?

WHAT TEST CONFIRMED DIAGNOSIS?

(Signed)....., M. D.
, 19 (Address)

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL

DATE OF BURIAL

19

20. UNDERTAKER

ADDRESS

ty important.
BE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW
REGISTRAR
CAUSE OF DEATH

S-1593