

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

Do not use this space.

38741

**1. PLACE OF DEATH**

County.....

Registration District No. 791

Township.....

Primary Registration District No. 1003

City St. Louis (No. City Hospital)

File No. ....

Registered No. 11160

St. .... Ward)

**2. FULL NAME**

(a) Residence. No. 1517 Carr St. 25 Ward.

(Usual place of abode)

(If nonresident, give city or town and State)

Length of residence in city or town where death occurred 4 yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

**PERSONAL AND STATISTICAL PARTICULARS**

3. SEX Female 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) widowed

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Feb. 9<sup>th</sup> 1853

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, .....hrs. or .....min.
	<u>76</u>	<u>9</u>	<u>5</u>	

**8. OCCUPATION OF DECEASED**

(a) Trade, profession, or particular kind of work. nil  
(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) Illinois

10. NAME OF FATHER John Hicks

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

12. MAIDEN NAME OF MOTHER Rachel Shepherd

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

14. Hospital Information (Address) City Hospital

15. FILED NOV 15 1929 REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) Nov. 14<sup>th</sup> 1929

17. I HEREBY CERTIFY, That I attended deceased from Nov. 4 1929, to Nov. 14 1929 that I last saw h. er, alive on Nov. 14 1929, and that death occurred, on the date stated above, at 12.00 noon

THE CAUSE OF DEATH\* WAS AS FOLLOWS:

93c Ch. Myocarditis & 106B Ch. Bronchitis  
(duration) ..... yrs. .... mos. .... ds.

CONTRIBUTORY (SECONDARY) non Tubercular  
(duration) ..... yrs. .... mos. .... ds.

**18. WHERE WAS DISEASE CONTRACTED**

IF NOT PLACE OF DEATH. No

19. DID AN OPERATION PRECEDE DEATH? ..... DATE OF .....

20. WAS THERE AN AUTOPSY? No

WHAT TEST CONFIRMED DIAGNOSIS? (Signed) R. Berg M. D.

11/14, 1929 (Address) City Hospital

\*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

St. Matthews Cem. 10-16 1929.

20. UNDERTAKER Bensieke Williams ADDRESS 1138 1/2 6<sup>th</sup> St.

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.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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SA  
11/10/19

11/10/19