

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

Do not use this space.

DEC 3 1936

1. PLACE OF DEATH

County.....

Registration District No. **791**

Township.....

Primary Registration District No. **1003**

City **St. Louis Mo.**

(No. **Barnes Hospital**)

File No. **42518**

Registered No. **11018**

St. Ward)

2. FULL NAME **Cecilia Pickles (Cecilia Pickels)**

(a) Residence, No. **3718 Mc Donald** St., **16** 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

**Female**

4. COLOR OR RACE

**White**

5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word)

**Widow**

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) **April-3-1854**

7. AGE

YEARS **82**

MONTHS **7**

DAYS **0**

IF LESS than 1 day, ..... hrs. or ..... min.

OCCUPATION

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc.

**At Home**

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.

10. Date deceased last worked at this occupation (month and year)

11. Total time (years) spent in this occupation

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) **New Orleans, La.**

FATHER MOTHER

13. NAME **John H. Scholl**

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) **Switzerland**

15. MAIDEN NAME **Elizabeth Bittkoeffler**

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) **Switzerland**

17. INFORMANT **Alice J. Pickels** (ADDRESS) **3718 Mc. Donald Ave.**

18. BURIAL, CREMATION, OR REMOVAL PLACE **New Pickers** DATE **Nov. 6 - 1936**

19. UNDERTAKER **Kaeker Stelderte** (ADDRESS) **2331 S. Broadway**

20. FILED **NOV 4 1936** **J. Budeck** Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) **11-3-1936**

22. I HEREBY CERTIFY, That I attended deceased from **11-1-36**, to **11-3-36**, 19**36**.

I last saw h. **lv** alive on **11-3-36**. Death is said

to have occurred on the date stated above, at **10:50 A.M.**

The principal cause of death and related causes of importance were as follows:

**Arteriosclerosis, generalized**  
**arteriosclerotic gangrene,**  
**right leg.**  
**Cardiac failure.**  
**Senile dementia**  
**Malnutrition**

Date of onset

**10-20-36**

**11-3-36**

Other contributory causes of importance:

Name of operation..... Date of.....

What test confirmed diagnosis? **Phys Exam** Was there an autopsy? **no**

23. If death was due to external causes (violence), fill in also the following: Accident, suicide, or homicide?..... Date of injury....., 19.....

Where did injury occur?..... (Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place.

Manner of injury.....

Nature of injury.....

24. Was disease or injury in any way related to occupation of deceased? **no**

If so, specify.....

(Signed) **Sydney O. Maugh**, M. D.

(Address) **BARNES HOSPITAL**

