

DEC 13 1937 MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

40053
Do not use this space.

1. PLACE OF DEATH

(a) County Registration District No. **791**
(b) Township **St. Louis** Primary Registration District No. **1003**
(c) City (d) Street No. **City Hospital No. 1** Registered No. **11040**
(e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME

Rebecca Sikes
(a) Residence, No. **1718 Mississippi St.** **23** (Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX **female** 4. COLOR OR RACE **white** 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) **Married**
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF **John Sikes**
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) **July 5, 1873**
7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min. **64 4 24**
8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc.
9. Industry or business in which work was done, as saw mill, bank, etc. **nil**
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) **Missouri**

FATHER 13. NAME **(Unknown) Summers**

FATHER 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) **Unknown**

MOTHER 15. MAIDEN NAME

MOTHER 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) **II**

17. INFORMANT (ADDRESS) **Hosp. Info M. Kent**

18. BURIAL, CREMATION, OR REMOVAL PLACE **Knobloch Gw.** DATE **12-2-37**

19. FUNERAL DIRECTOR (ADDRESS) **Albert H. Horn**
429 N. Euclid

20. FILED **NOV 30 1937** **J. T. Bredeck**
Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) **11/29/37** 19
22. I HEREBY CERTIFY that I attended deceased from **11/29/37** to **11/29/37**, 19...
her **11/29/37**, 19... Death is said
I last saw h. alive on 19... Death is said
to have occurred on the date stated above, at **4. p.** m.

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

Cerebral Hemorrhage Date of onset **11/29/37**

Other contributory causes of importance:

Variation ulcer of leg.

Name of operation Date of
What test confirmed diagnosis? Was there an autopsy? **Yes**

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?
If so specify: **Cerebral Hemorrhage** M. D.
Chas. J. Fassett
(Address) **City Hospital No. 1**

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.

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STATEMENT BY LICENSED EMBALMER

I, _____, Licensed Embalmer No. _____

hereby certify that the body recorded on the reverse side of this certificate was embalmed by _____

_____ L. E. _____

No. _____ or by _____, Registered Apprentice No. _____

working under my personal supervision.

Signed *Benz C. Duncan* _____

Licensed Embalmer No. *2272* _____

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