

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

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

24069
Do not use this space.

REC'D AUG 12 1938

1. PLACE OF DEATH

(a) County
 (b) Township
 (c) City St. Louis
 (d) Street No. City Hospital No. 1
 (If death occurred in Hospital or Institution, write its name instead of street and number)
 (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. moa. ds.
 D. 3742
 2. PRINT FULL NAME Laura Hickman
 (a) Residence, No. 2511 a Prairie
 (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) widowed
 5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF ROBERT HICKMAN
 6. DATE OF BIRTH (MONTH, DAY, AND YEAR) May 17, 1859
 7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
~~70~~ 79 2 10
 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) St. Louis, Missouri
 13. NAME UNKNOWN
 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) UNKNOWN
 15. MAIDEN NAME UNKNOWN
 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) UNKNOWN
 17. INFORMANT Hosp. Info M. Kent
 (ADDRESS)
 18. BURIAL, CREMATION, OR REMOVAL
 PLACE CALVARY CEMETERY DATE JULY 30, 1938
 19. FUNERAL DIRECTOR Joseph and Brothers
 (ADDRESS) 277 St Louis ave.
 20. FILED JUL 28 1938
J. V. Biedock
 Local Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 7/27/38, 19
 22. I HEREBY CERTIFY, That I attended deceased from 7/14/38, 19, to 7/27/38, 19.
 I last saw her arrive on 7/27/38, 19. Death is said to have occurred on the date stated above, at 12:055p.
 The principal cause of death and related causes of importance were as follows:
Senile Psychosis
107a
 Date of onset 2/1/38
 Other contributory causes of importance:
Neurostatic Pneumonia
Thrombosis abscess, carcinoma
 Name of operation Removal of adenoid Date of 7/15/38
 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 _____
 (Signed) Thos. J. Haugk, M. D.
 (Address) 1515 Lafayette

STATEMENT BY LICENSED EMBALMER

Harb Goodhart Licensed Embalmer No. *2777*
hereby certify that the body recorded on the reverse side of this certificate was embalmed by *Harb Goodhart*

L. E.

No. _____ or by _____ Registered Apprentice No. _____
working under my personal supervision.

Signature *Harb Goodhart*
Licensed-Embalmer No. *2777*

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.)