

APR 12 1939

MISSOURI STATE BOARD OF HEALTH  
BUREAU OF VITAL STATISTICS  
CERTIFICATE OF DEATH8977  
Do not use this space.

## 1. PLACE OF DEATH

(a) County..... Registration District No..... 1003  
 (b) Township..... Primary Registration District No.....  
 (c) or City..... St. Louis (d) Street No. Desloge Hospital St.  
 (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. da. (f) How long in U. S., if of foreign birth? yrs. mos. da.

Registered No. 2742

## 2. PRINT FULL NAME

Etha Hickman  
 (a) Residence, No. 4047 Castleman Ave St. 17  
 (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 7 Male	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 Gilbert T. Hickman		
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) April 1 1886		
7. AGE	YEARS 52	MONTHS 11
		DAYS 20
	If LESS than 1 day, ..... hrs. or ..... min.	
OCCUPATION	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. At Home	
	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 Joseph Wilson	
	14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Missouri	
MOTHER	15. MAIDEN NAME Alma Cunningham	
	16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Missouri	
17. INFORMANT Gilbert T. Hickman (ADDRESS) 4047 Castleman Ave		
18. BURIAL, CREMATION, OR REMOVAL PLACE Sunset Burial Park DATE March 23 1939		
19. FUNERAL DIRECTOR (NAME) Postz Brothers (ADDRESS) 3029 Lafayette Ave		
20. FILED MAR 23 1939 J. B. Bucher Local Registrar		

## MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) March 21 1939

22. I HEREBY CERTIFY, That I attended deceased from 2-18, 1939 to 3-21, 1939

I last saw her alive on 3-21, 1939. Death is said to have occurred on the date stated above, at 10:30 P.M.

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

acute pancreatitis  
 (pancreatic necrosis) 3-7-39  
 Date of onset

Other contributory causes of importance:

post-operative wound  
 infection

Name of operation Cholecystectomy, Stones Date of 3-7-39

What test confirmed diagnosis? Autopsy (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? No

If so, specify

(Signed) Craig J. Desautels M. D.

(Address) Francis Desloge Hospital

Dr. W. T. Conklin  
University of Pennsylvania  
J-4536

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....

....., Registered Apprentice No.....

working under my personal supervision.

Signed *Frank J. Owens*

Licensed Embalmer No. 2245

P. O. Address.....

**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.)**

**If this body is not embalmed, above space should be left blank.**

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

Do not use this space.

**1. PLACE OF DEATH**

(a) County..... Registration District No. 791  
 (b) Township..... Primary Registration District No. 1003 Registered No. 2742  
 (c) City..... or (d) Street No. DeSloge Hosp. St.  
 (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. 60 How long in U. S., if of foreign birth? yrs. mos. ds.

**2. PRINT FULL NAME** Etha Hickman

(a) Residence, No. St. 17 (If nonresident, give city or town and State)  
 (Usual place of abode, if no street address, write county or city)

**PERSONAL AND STATISTICAL PARTICULARS**

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

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.

OCCUPATION 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.  
 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)

FATHER 13. NAME 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

MOTHER 15. MAIDEN NAME 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

17. INFORMANT (ADDRESS)

18. BURIAL, CREMATION, OR REMOVAL PLACE DATE 19

19. FUNERAL DIRECTOR (NAME) (ADDRESS)

20. FILED 4-17 19 39 J. F. Budeck Local Registrar.

**MEDICAL CERTIFICATE OF DEATH**

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 19

22. I HEREBY CERTIFY, That I attended deceased from 19 to 19. I last saw him alive on 19. Death is said to have occurred on the date stated above, at m. The principal cause of death and related causes of importance were as follows:

Date of onset

Other contributory causes of importance:

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

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) M. D.

TE PL A L R, WITH UNFADING I. ---THIS IS A PERM T 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.

5-8977

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**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....

....., Registered Apprentice No.....  
working under my personal supervision.

Signed.....

Licensed Embalmer No.....

P. O. Address.....

**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.)**

**If this body is not embalmed, above space should be left blank.**