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.

1939 JUN 12 1939

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

16996
Do not use this space.

1. PLACE OF DEATH
(a) County ..... Registration District No. .....
(b) Township ..... Primary Registration District No. ..... Registered No. 4530
(c) or City Saint Louis (d) Street No. 4453a St. Ferdinand Avenue 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 Unavailable (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME Irene Hicks
(a) Residence, No. 4453a St. Ferdinand Ave. St. 11
(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: Negro
5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word): Married
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF: William Hicks
6. DATE OF BIRTH (MONTH, DAY, AND YEAR): Unk. abt. 1899
7. AGE: Abt. 40 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.: Housewife
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): May 1939
11. Total time (years) spent in this occupation: Unk.

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY): Mississippi

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

MOTHER
15. MAIDEN NAME: Clara-Unavailable
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY): Unavailable Mississippi

17. INFORMANT (ADDRESS): William Hicks 4453a St. Ferdinand Avenue
18. BURIAL, CREMATION, OR REMOVAL
PLACE Washington Park DATE 5/19/39 19
19. FUNERAL DIRECTOR (NAME) (ADDRESS): Charles J. Gates 4107-09 Finney Avenue
20. FILED MAY 17 1939 19 J. F. Budick Local Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR): May 14th, 1939
22. I HEREBY CERTIFY, That I attended deceased from May 13th, 1939, to May 14th, 1939
I last saw her alive on May, 1939 Death is said to have occurred on the date stated above, at 6:30 a.m.
The principal cause of death and related causes of importance were as follows:

	Date of onset
Cerebral Apoplexy due to Cerebral Hemmorhage	

Other contributory causes of importance:
None

Name of operation None Date of .....
What test confirmed diagnosis? Clinical 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) Ivan L. Perry, M. D.
(Address) 4452 Kennerly Avenue

(Licensed Embalmer's Statement on Reverse Side)

Em. Perry

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 James A. Johnson, Registered Apprentice No. ....., working under my personal supervision.

Signed James A. Johnson

Licensed Embalmer No. 3522

P. O. Address 4107-09 Finney Ave.

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.