

NOV 13 1939 791
Registration District No.

Primary Registration District No.

1. PLACE OF DEATH:

(a) County 1
(b) City or town St. Louis
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
Lutheran Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 35 years (Specify whether years, months or days)
In this community 35 years

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County 1
(c) City or town St. Louis 16
(If outside city or town limits, write "RURAL")
(d) Street No. 3726 Wyoming
(If rural, give location)
(e) If foreign born, how long in U. S. A. ? _____ years.

8. (a) PRINT FULL NAME

KATE LICKLIDER 202

8. (b) If veteran, name war _____

8. (c) Social Security No. None

4. Sex Female

5. Color or race White

6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Thomas E. Licklider

6. (c) Age of husband or wife if alive 73 years

7. Birth date of deceased May 27 1879
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	60	4	5	_____ hr. _____ min.

9. Birthplace Joplin Missouri
(City, town, or county) (State or foreign country)

10. Usual occupation Household

MOTHER FATHER

12. Name John Dunagan

13. Birthplace Unknown
(City, town, or county) (State or foreign country)

14. Maiden name Missouri Jackson

15. Birthplace Unknown
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature Thomas E. Licklider

(b) Address 3726 Wyoming

17. (a) Burial (b) Date thereof 10/4/39
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Valhalla Cemetery

18. (a) Signature of funeral director Widenwider Funeral Home

(b) Address 1936 St. Louis Avenue

19. (a) OCT 3 1939 (b) [Signature]
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month October day 2
year 1939 hour 7 minute 45 A. M.

21. I hereby certify that I attended the deceased from Sept. 11, 39
1939, to Oct. 2, 1939,
that I last saw h. u alive on Oct. 1, 1939,
and that death occurred on the date and hour stated above.

Immediate cause of death Cancer of sigmoid Duration 6 mos.

Due to Paralysis of arm & legs 3 days

Due to _____

Other conditions [Handwritten]
(Include pregnancy within 3 months of death)

Major findings: Cancer of sigmoid c
Of operations observed

Of autopsy _____

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) ho

(b) Date of occurrence _____

(c) Where did injury occur? ho
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place?

While at work? _____ (Specify type of place)
(e) Means of injury _____

23. Signature [Signature] (M.D. or other)

Address St. Louis Date signed 10/2/39

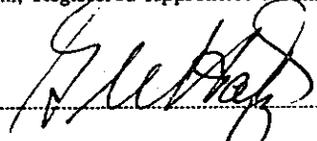
CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. N. B. - Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state

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. 3737

P. O. Address. 1936 St. James

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.