S. No. 2
—11-10-39
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WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
AUG 23 1940

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 23486
5931

Registration District No. 791 Primary Registration District No. 1003 Registrar's No.

1. PLACE OF DEATH:

(a) County
(b) City or town St. Louis
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
Park Lane Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 12 hours (Specify whether years, months or days)
In this community

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County
(c) City or town St. Louis
(If outside city or town limits write "RURAL")
(d) Street No. 2855 Arlington Ave.
(If rural, give location)
(e) If foreign born, how long in U. S. A.? * years.

3. (a) PRINT FULL NAME Infant Pickel 240

3. (b) If veteran, name war None

3. (c) Social Security No. None

4. Sex Female

5. Color or race White

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

6. (b) Name of husband or wife *

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

7. Birth date of deceased July 13, 1940 (Month) (Day) (Year)

8. AGE: Years | Months | Days | If less than one day 12 hr. min.

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

10. Usual occupation None

11. Industry or business None

FATHER
12. Name Robert Pickel.
13. Birthplace St. Louis, (City, town, or county) Missouri. (State or foreign country)

MOTHER
14. Maiden name Novella Williams.
15. Birthplace ? (City, town, or county) Missouri. (State or foreign country)

16. (a) Informant Mr. Robert Pickel.
(b) Address 2855 Arlington Ave.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 7-15-1940. (Month) (Day) (Year)
(c) Place: burial or cremation Calvary Cemetery.

18. (a) Signature of funeral director Geo. L. Pleitsch Inc.
(b) Address 5966-68 Easton Ave.

19. (a) JUL 15 1940 (Date received by registrar) (b) J. F. Bredeck (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 13 year 1940 hour 10 minute 30 P.M.

21. I hereby certify that I attended the deceased from 10:30 A.M. 7/13/40, 19, to 10:30 P.M. 7/13/40 that I last saw h er alive on 10:30 P.M. 7/13/40, 19; and that death occurred on the date and hour stated above.

Immediate cause of death — Duration

Congential heart lesion. Premature.

Due to

Due to

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations

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)
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? (Specify type of place)
While at work? (e) Means of injury

23. Signature (M. D. or other)
Address Date signed

(Licensed Embalmer's Statement on Reverse Side)

Mr. Smith