DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED OCT 7 1941

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 32636

X25390

Registration District No. 784 Primary Registration District No. 200 Registrar's No. 1876

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH:
(a) County St Louis
(b) City or town Koch (If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Robert Koch Hospital (If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 3 days (Specify whether
In this community 25 years (years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County St Louis
(c) City or town St Louis (If outside city or town limits, write "RURAL")
(d) Street No. 6800 A Virginia Ave (If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME ARNOLD KICKEL
3. (b) If veteran, name war NO
3. (c) Social Security 489-01-3392
4. Sex Male
5. Color or race white
6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife Josephine Kickel nee Alvarez
6. (c) Age of husband or wife if alive years
7. Birth date of deceased Dec (Month) 25 (Day) 1883 (Year)

8. AGE:	Years	Months	Days	If less than one day
	58	8	14	hr. min.

9. Birthplace Collinsville (City, town, or county) Ill (State or foreign country)
10. Usual occupation Laborer
11. Industry or business
FATHER
12. Name August Kickel
13. Birthplace August Kickel (City, town, or county) Germany (State or foreign country)
MOTHER
14. Maiden name Unknown
15. Birthplace " " (City, town, or county) " (State or foreign country)
16. (a) Informant Hospital Record
(b) Address Robert Koch Hosp
17. (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 9-11-41 (Month) (Day) (Year)
(c) Place: burial or cremation MT. Hope Cemetery
18. (a) Signature of funeral director Southern Funeral Home
(b) Address 6322 So. Grand
19. (a) SEP 10 1941 (Date received local registrar) (b) C. G. McGovern MD (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept day 8th year 1941 hour 4 minute 40 P.M.
21. I hereby certify that I attended the deceased from Sept 5th, 1941, to Sept 8th, 1941, that I last saw him alive on Sept 8, 1941; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Pulmonary Tuberculosis	6 mo +
Due to	
Due to	
Other conditions uremia (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 Frank Cohen (M. D. or other) MD
Address Robert Koch Hosp Date signed Sept 8/41

(Licensed Embalmer's Statement on Reverse Side)

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 Virgil L. Berryman

Licensed Embalmer No. 4018

P. O. Address St. Louis Mo

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply wi the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.

No. 2B
—8-21-41
T X29288

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

2. USUAL RESIDENCE OF DECEASED:
(a) State (b) County
(c) City or town (If outside city or town limits, write "RURAL")
(d) Street No. (If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME Arnold Kickel
3. (b) If veteran, name war
3. (c) Social Security No.
4. Sex M
5. Color or race W
6. (a) Single, widowed, married, divorced M
6. (b) Name of husband or wife
6. (c) Age of husband or wife if alive
7. Birth date of deceased Dec 25 1883 (Month) (Day) (Year)
8. AGE: Years 58 Months 8 Days 14 If less than one day hr. min.
9. Birthplace (City, town, or county) (State or foreign country)
10. Usual occupation
11. Industry or business
MOTHER FATHER
12. Name
13. Birthplace (City, town, or county) (State or foreign country)
14. Maiden name
15. Birthplace (City, town, or county) (State or foreign country)
16. (a) Informant
(b) Address
17. (a) (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)
(c) Place: burial or cremation
18. (a) Signature of funeral director
(b) Address
19. (a) 9-10-41 (Date received local registrar) (b) E. Sm[illegible] (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept day
year 1941 hour minute M.
21. I hereby certify that I attended the deceased from 19 to 19;
that I last saw him alive on 19;
and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death	
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

SUPPLEMENTARY