

FILED NOV 18 1943 18

Registration District No. _____ Primary Registration District No. **1003**

1. PLACE OF DEATH:

(a) County _____

(b) City or town St. Louis, Missouri
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution De Paul Hospital
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution _____ (Specify whether
In this community _____ years, months or days) (Specify whether
years, months or days)

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. 3908 Lincoln Ave.,
(If rural, give location)

(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME Mary Hickey

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex female 5. Color or race white 6. (a) Single, widowed, married, divorced widow

6. (b) Name of husband or wife Michael Hickey 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased May 19th 1876
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day

67	5	13	_____ hr. _____ min.
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9. Birthplace St. Louis, Missouri U
(City, town, or county) (State or foreign country)

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER { 12. Name (unknown) O&Toole

13. Birthplace Ireland 4
(City, town, or county) (State or foreign country)

14. Maiden name Cecelia Devine

15. Birthplace Ireland 4
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Cecelia Gunn,

(b) Address 3908 Lincoln Ave.,

17. (a) Burial (b) Date thereof 11-6-43
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Calvary Cemetery

18. (a) Signature of funeral director Sullivan Brothers,

(b) Address 2849 No. Euclid Ave.,

19. (a) NOV 3 1943 J. F. Bussack
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month November day 2nd
year 1943 hour 10:45 minute P. M.

21. I hereby certify that I attended the deceased from Petaher
23rd 1943 to November 2nd 1943
that I last saw her alive on November 2nd 1943
and that death occurred on the date and hour stated above.

Immediate cause of death _____

Intestinal Obstruction 8 days

Due to Carcinoma Sigmoid 2 years

Other conditions _____
(Include pregnancy within 3 months of death)

Major findings: 41
Of operations Carcinoma Sigmoid

Of autopsy _____

Duration

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? _____

While at work? _____ (Specify type of place)

23. Signature J. F. Gallagher (M. D. or other) _____

Address 3903 Olive Date signed 11/3/43

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

Dr. J. F. Gallagher
De Paul Hospital

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 Albert J. Mayfield

Licensed Embalmer No. 3077

P. O. Address St Louis Mo

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, fact should be so stated above.