

Registration District No. **318**

Primary Registration District No. **1003**

Registrar's No. **230**

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:
residence-4475 West Pine Blv'd.
(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)

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. 4475 West Pine Blv'd.
(If rural, give location)
 (e) Citizen of foreign country? No (Yes or No)
 If yes, name country _____

3. (a) PRINT FULL NAME JAMES H. HICKS

3. (b) If veteran, name war unknown 3. (c) Social Security No. none

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

6. (b) Name of husband or wife Minnie Hicks 6. (c) Age of husband or wife if alive 61 years

7. Birth date of deceased June 27 1876
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
67 6 11 hr. _____ min.

9. Birthplace Paragould Arkansas
(City, town, or county) (State or foreign country)

10. Usual occupation retired druggist

11. Industry or business _____

MOTHER FATHER { 12. Name unknown Hicks.
 { 13. Birthplace unknown
(City, town, or county) (State or foreign country)
 { 14. Maiden name Margaret Scoggins.
 { 15. Birthplace unknown
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Minnie Hicks

(b) Address 4475 West Pine Blv'd.

17. (a) entombment (b) Date thereof 1-10-44
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Oak Grove Mausoleum

18. (a) Signature of funeral director C. R. LUPTON & SONS

(b) Address 7233 Delmar Blv'd. St. Louis

19. (a) JAN 19 1944 (b) _____
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month January day 8th
 year 1944 hour 1:00 minute 30 A. M.

21. I hereby certify that I attended the deceased from April 1, 1943 to Jan 8, 1944
 that I last saw him alive on Jan 7, 1944
 and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral aneurysm
(non-traumatic)

Due to arterial hypertension

Due to _____
 Other conditions 8/8
(Include pregnancy within 3 months of death)

Major findings: _____
 Of operations _____
 Of autopsy _____

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) (c) Means of injury
 23. Signature J. P. [unclear] (M. D. or other) MD
 Address 402 Rusten Blv'd Date signed 1-9-44

Duration 8 mo
 PHYSICIAN _____
 Underline the cause to which death should be charged statistically.

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

4500 Olive Street
FO-3800
1 to 3 P.M.

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 Bradford A. Miles

Licensed Embalmer No. 2901

P. O. Address University City -

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.