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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
LED JAN 10 1944
STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 0

Registration District No. 317

Primary Registration District No. 6076

Registrar's No. 15

1. PLACE OF DEATH: St Louis

(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 & location)

(d) Length of stay: In hospital or institution 1 mo 6 day (Specify whether years, months or days)

In this community 1 1/2 years (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. 2533 S. Broadway
(If rural, give location)

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

3. (a) PRINT FULL NAME HICKS, ORVILLE COLUMBUS

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan day 2
year 1944 hour 7 minute 00 A. M.

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

21. I hereby certify that I attended the deceased from April 27, 1943 to Jan 2, 1944
that I last saw him alive on Jan 2, 1944
and that death occurred on the date and hour stated above.

4. Sex M 5. Color or Race W 6. (a) Single, widowed, married, divorced M

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

7. Birth date of deceased Aug 2, 1910
(Month) (Day) (Year)

Immediate cause of death Pulm tuberculosis Duration 14 ±

8. AGE: Years 33 Months 5 Days 0 If less than one day hr. — min. —

Due to —

Due to —

9. Birthplace Greenville Mo
(City, town, or county) (State or foreign country)

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

10. Usual occupation laborer

Major findings: Of operations Peri-anal abscess PHYSICIAN —
Of autopsy 1321
Underline the cause to which death should be charged statistically.

11. Industry or business —

12. Name Nathan Hicks

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

14. Maiden name Pardee Sidwell

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

16. (a) Informant Hospital Record

(b) Address Robert Koch Hosp

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? —

17. (a) Burial (b) Date thereof 1/5/44
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation New St Marcus Ch.

While at work? (Specify type of place) (c) Means of injury —

18. (a) Signature of funeral director Frank Brod

(b) Address 2201 S. Grand

19. (a) JAN 6 - 1944 (b) E. G. McKernan, M.D.
(Date received local registrar) (Registrar's signature)

23. Signature Frank Cohen (M. D. or other) —
Address Robert Koch Hosp Date signed 1/2/44

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

MOTHER FATHER

707

(Licensed Embalmer's Statement on Reverse Side)

JUL 23 1945

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 Wm A Stewart

Licensed Embalmer No. 3722

P. O. Address 412 Dunbar

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.