

FILED APR 1 1944
318

Registration District No. _____ Primary Registration District No. 1003

Registrar's No. 2870

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:
City Infirmary 0
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution _____
In this community 15 years (Specify whether years, months or days)

3. (a) PRINT FULL NAME (Julia) Amelia Kick

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

4. Sex <u>female</u>	5. Color or race <u>white</u>	6. (a) Single, widowed, married, divorced, widow <u>Divorced widow</u>
6. (b) Name of husband or wife <u>Frank</u>	6. (c) Age of husband or wife if alive _____ years	
7. Birth date of deceased <u>7-29-1859</u> <small>(Month) (Day) (Year)</small>		

8. AGE:

Years	Months	Days	If less than one day
<u>84</u>	<u>7</u>	<u>26</u>	_____ hr. _____ min.

9. Birthplace Ellisville, Mo. (City, town, or county) 0 (State or foreign country)

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER

12. Name Adam Sontag

13. Birthplace unknown (City, town, or county) 9 (State or foreign country)

14. Maiden name unknown

15. Birthplace unknown (City, town, or county) 9 (State or foreign country)

16. (a) Informant C. Hannon

(b) Address 5800 Arsenal St.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-28-44
(Month) (Day) (Year)

(c) Place: burial or cremation Summit Cemetery

18. (a) Signature of funeral director Louis A. Bopp, Inc
Rockwood, Mo.

(b) Address _____

19. (a) WAR 28 1944 (Date received local registrar) (b) J. F. Brudick (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED: 000

(a) State Missouri (b) County 17

(c) City or town St. Louis 912
(If outside city or town limits, write "RURAL")

(d) Street No. 911 N. Euclid
(If rural, give location)

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Mar. 25 day 4:25 p.m. 1944 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from Mar. 15, 1944 to Mar. 25, 1944, 19____; that I last saw her alive on Mar. 25, 1944, 19____; and that death occurred on the date and hour stated above.

Immediate cause of death:
Hypertensive cardio-vascular disease (decompensated)
Coronary occlusion

Due to _____

Other conditions (Include pregnancy within 3 months of death)
Old fracture left hip

Major findings Of operations
Did not contribute to cause of autopsy None of death.

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) (e) Means of injury _____

23. Signature Thomas J. Sweetman, M.D. (M. D. or other)
Address 5800 Arsenal St Date signed 3-25-44

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

6-2
2-43
17-39
X355697

0282

0282

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..... *Felix L. Linnard*

Licensed Embalmer No. *3034*

P. O. Address..... *Kirkwood n*

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.

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 9147
Registrar's No. 2870

Registration District No. 218

Primary Registration District No. 1003

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

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:
.....
(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)

3. (a) PRINT FULL NAME

(Julia) Amelia Beck

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

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

6. (b) Name of husband or wife..... 6. (c) Age of husband or wife if alive..... Years.....

7. Birth date of deceased July 29
(Month) (Day) (Year)

8. AGE: Years 84 Months 7 Days..... If less than one day, min.....

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

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)..... (b) Date thereof..... (Month) (Day) (Year)
(Burial, cremation, or removal)

(c) Place: burial or cremation.....

18. (a) Signature of funeral director.....

(b) Address.....

19. (a) APR 22 1944 F. Bruleck
(Date received local registrar) (Registrar's signature)

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.....

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month..... Year.....
..... 19.....

21. I hereby certify that I attended the deceased from..... 19.....
that I last saw him..... alive on..... 19.....
and that death occurred on the date and hour stated above.
Immediate cause of death.....

Due to.....

Due to.....

Other conditions..... (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..... (M. D. or other).....

Address..... Date signed.....

SUBSTITUTED

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

