

FILED NOV 1 1944

Registration District No. _____

Primary Registration District No. _____

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:
St. Louis City Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 17 days
(Specify whether _____)
In this community _____
years, months or days)

3. (a) PRINT FULL NAME Baby Hicks

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

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

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

7. Birth date of deceased September 13th, 1944
(Month) (Day) (Year)

8. AGE: Years _____ Months _____ Days 17 If less than one day _____ hr. _____ min.

9. Birthplace St. Louis, Missouri
(City, town, or county) (State or foreign country)

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER { 12. Name Sherman Hicks
13. Birthplace _____
(City, town, or county) (State or foreign country)
14. Maiden name Jean Barham
15. Birthplace Ark.
(City, town, or county) (State or foreign country)

16. (a) Informant M. Renard
(b) Address St. Louis City Hospital

17. (a) _____ (b) Date thereof 11 26 44
(Month) (Day) (Year)

(c) Place: burial or cremation City Crematory

18. (a) Signature of funeral director W. J. White

(b) Address City Hospital

19. (a) NOV 26 1944 (b) J. J. [Signature]
(Date received local registrar) (Registrar's signature)

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. 1016 Barton
(If rural, give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept. day 30th
year 1944 hour 7:50 minute _____ P. _____ M. _____

21. I hereby certify that I attended the deceased from 9/13/44
_____ 19 _____ to Sept. 30th 19 44
that I last saw her alive on Sept. 30th 19 44
and that death occurred on the date and hour stated above.

Immediate cause of death Diarrhea of Newborn of Milk

Due to _____

Due to _____

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

Major findings: Of operations _____

Of autopsy Prematurity Diarrhea

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? _____

(e) While at work _____ (Specify type of place)
(f) Manner of injury _____

23. Signature [Signature] (Name or other) _____

Address City Hospital Date signed _____

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

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

10
17
9

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.....

Licensed Embalmer No.....

P. O. Address.....

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.