

S. No. 2
M-5-43
7-5-17-39
- I X36571

4699

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No.

FILED FEB 24 1945
318

Registration District No.

1003

Registrar's No.

1021

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 Sanitarium 1
(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..... 000
(c) City or town..... St. Louis 17
(If outside city or town limits, write "RURAL")
(d) Street No. 1409 S. 7th St. 23
(If rural, give location)
(e) Citizen of foreign country? 0 (Yes or No)
If yes, name country.....

3. (a) PRINT FULL NAME Samuel R. Pickle

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

4. Sex Male 5. Color or race White
6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife Lilly Pickle
6. (c) Age of husband or wife if alive 62 years
7. Birth date of deceased October 30 1875
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
69 3 1hr.min.

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

10. Usual occupation Laborer

MOTHER FATHER { 11. Industry or business

12. Name Thomas Pickle

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

14. Maiden name Unknown

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

16. (a) Informant Louis Pickle

(b) Address Mayfield, Kentucky

17. (a) Removal (b) Date thereof 2-1-45
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Fulton, Kentucky

18. (a) Signature of funeral director Albert H. Hoppe

(b) Address 4700 Washington Blvd.

19. (a) FEB 1 1945 (b) J. F. Beards
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan. day 31
year 1945 hour 11 minute 30 M.

21. I hereby certify that I attended the deceased from
....., 19....., to, 19.....;
that I last saw h..... alive on, 19.....;
and that death occurred on the date and hour stated above.

Immediate cause of death.....
Arterio Sclerosis
Due to.....
Cardiac Hypertrophy
Due to.....
Asa
Other conditions.....
(Include pregnancy within 3 months of death)

Major findings:
Of operations.....
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?

(Specify type of place)
While at work..... (a) Means of injury.....
23. Signature W. G. Perry (M. D. or other) 3
Address Fulton, Ky Date signed 2/1/45

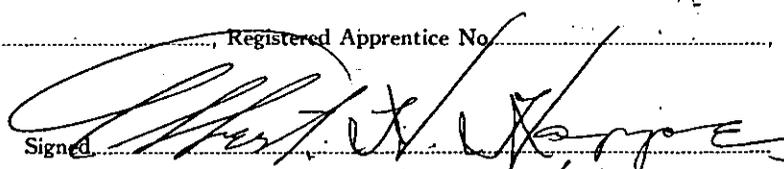
WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

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. 1861

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.