

S. No. 2
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 Rev. 5-17-39
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DEPARTMENT OF COMMERCE
 BUREAU OF THE CENSUS
 THE STATE BOARD OF HEALTH OF MISSOURI
 STANDARD CERTIFICATE OF DEATH

FILED AUG 24 1945
 Registration District No. 318 Primary Registration District No. 1003
 State File No. Registrar's No. 7135

1. PLACE OF DEATH:
 (a) County St. Louis
 (b) City or town St. Louis
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution:
 2700 Shenandoah Avenue 7
 (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 Ervin Sicking
 3. (b) If veteran, name war. 3. (c) Social Security No. 497-03-5765

4. Sex Male 0 5. Color or race White 6. (a) Single, widowed, married, divorced Married/
 6. (b) Name of husband or wife Josephine Sicking 6. (c) Age of husband or wife if alive 39 years
 7. Birth date of deceased June 20, 1903
 (Month) (Day) (Year)

8. AGE: Years 42 Months 1 Days 23 If less than one day hr. min.

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

10. Usual occupation Laborer

11. Industry or business

12. Name Henry Sicking

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

14. Maiden name Emma Taylor

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

16. (a) Informant Josephine Sicking

(b) Address 405 Sidney Street

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof August 16/45
 (Month) (Day) (Year)

(c) Place: burial or cremation St. Paul Churchyard

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

(b) Address 2201 So. Grand Blvd.

19. (a) AUG 14 1945 J. F. Brebeck
 (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
 (a) State Missouri (b) County 000
 (c) City or town St. Louis 17 23
 (If outside city or town limits, write "RURAL")
 (d) Street No. 405 Sidney Street 9
 (If rural, give location)
 (e) Citizen of foreign country? 0 (Yes or No)
 If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month August day 13
 year 1945 hour 9 minute 30 AM

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

Immediate cause of death Primary Occlusion
 Duration

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) (e) Means of injury 5
 Signature Gabriel E Taylor Dep Car
 (M. D. or other)

23. Address 1300 Clark D.S. signed 8-14-45

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. 3881

..... 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.