

S. No. 2  
M-5-43  
7-5-17-39  
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DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS  
THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **38346**  
Registrar's No. **166**

Registration District No. **310** Primary Registration District No. **3058**

1. PLACE OF DEATH:  
(a) County **St. Charles**  
(b) City or town **St. Charles**  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
**St. Joseph Hospital 1**  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution **6 hours** (Specify whether  
In this community \_\_\_\_\_ years, months or days)

2. USUAL RESIDENCE OF DECEASED:  
(a) State **Missouri** (b) County **St. Charles**  
(c) City or town **St. Charles**  
(If outside city or town limits, write "RURAL")  
(d) Street No. **427 North Sixth Street**  
(If rural, give location)  
(e) Citizen of foreign country? **No** (Yes or No)   
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME **Nancy Catherine Hickman**  
3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security 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 **July 3 1945**  
(Month) (Day) (Year)  
8. AGE: Years Months Days If less than one day  
**4 6** hr. min.

MEDICAL CERTIFICATION  
20. DATE OF DEATH: Month **Nov.** day **9**  
year **1945** hour **12:15** minute **A** M.  
21. I hereby certify that I attended the deceased from **Birth**  
**July 3** 19**45**, to **Nov 9** 19**45**  
that I last saw her alive on **Nov 9** 19**45**  
and that death occurred on the date and hour stated above.

Immediate cause of death \_\_\_\_\_ Duration  
**Ac. Broncho pneumonia 2 day**  
Due to \_\_\_\_\_  
Due to \_\_\_\_\_  
Other conditions \_\_\_\_\_  
(Include pregnancy within 3 months of death)

9. Birthplace **St. Charles Missouri**  
(City, town, or county) (State or foreign country)  
10. Usual occupation **None - child**  
11. Industry or business \_\_\_\_\_  
12. Name **James Hickman**  
13. Birthplace **St. Charles Missouri**  
(City, town, or county) (State or foreign country)  
14. Maiden name **Mary Rita Grote**  
15. Birthplace **St. Louis Missouri**  
(City, town, or county) (State or foreign country)  
16. (a) Informant **James and Mary Rita Hickman**  
(b) Address **427 N. 6th-St. Charles, Mo.**  
17. (a) **burial** (b) Date thereof **Nov. 10-1945**  
(Burial, cremation, or removal) (Month) (Day) (Year)  
(c) Place: burial or cremation **St. Peter-St. Charles, Mo.**  
18. (a) Signature of funeral director **H. C. Dallmeyer + Sons Co**  
(b) Address **801 N. 2nd-St. Charles, Mo.**  
19. (a) **11-10-1945** (b) **Conrad S. Paul**  
(Date received local registrar) (Registrar's signature)

Major findings:  
Of operations \_\_\_\_\_  
Of autopsy \_\_\_\_\_  
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? **Mo.**  
(Specify type of place) \_\_\_\_\_  
(e) Means of injury \_\_\_\_\_  
23. Signature **Vernon A. Schneider** (M. D. or other) **MD**  
Address **St. Charles, Mo.** Date signed **11/10/45**

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

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RECEIVED

District Health Officer No. 9,

District File Number: \_\_\_\_\_

Date Filed 12-11-45

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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: \_\_\_\_\_

*Philip A Miceli*

, Registered Apprentice No. 388

working under my personal supervision.

Signed \_\_\_\_\_

*John E. Dallmeyer*

Licensed Embalmer No. 2951

P. O. Address \_\_\_\_\_

*St Charles Mo*

**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.**