V. S. No. 2
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WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

FILED JAN 11 1946

State File No. 39275

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 11726

1. PLACE OF DEATH:

(a) County St. Louis Mo.

(b) City or town (If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: City Hosp. #10

(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 Mo (b) County

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

(d) Street No. 1608 = S. 7th St. (If rural, give location)

(e) Citizen of foreign country? 0 (Yes or No)

If yes, name country

3. (a) PRINT FULL NAME Dorrene Hickman

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex Female

5. Color or race Neg

6. (a) Single, widowed, married, divorced

6. (b) Name of husband or wife

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

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

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

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

10. Usual occupation Unknown

11. Industry or business Unknown

FATHER
12. Name Unknown
13. Birthplace (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name Unknown
15. Birthplace (City, town, or county) (State or foreign country)

16. (a) Informant Thos. F. Callaway

(b) Address 1300 Clark St. W

17. (a) Anatomical Board (Burial, cremation, or removal) (b) Date thereof 12-3-46 (Month) (Day) (Year)

(c) Place: burial or cremation Wilmington

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

(b) Address 3500 Rutgers

19. (a) JAN 3 1946 (Date received local registrar) J. F. Brenesh (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec day 14 year 1945 hour 10 minute 5 am 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.

	Duration
Immediate cause of death	
Due to Meningococcemia	
Due to N. M. A.	
Other conditions (Include pregnancy within 3 months of death)	
Major findings: Of operations	
Of autopsy	

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? (e) Means of injury

23. Signature Alfred J. Perry (M. D. or other)

Address Date signed 12/28/45

(Licensed Embalmer's Statement on Reverse Side)

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.