

Registered in District No. **318** Primary Registration District No. **1003**

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:
916 Chambers Street.
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution..... (Specify whether
In this community 20 yrs.....
years, months or days)

3. (a) PRINT FULL NAME Charles Hickman

3. (b) If veteran, name war Yes 3. (c) Social Security No. 497-10-5917

4. Sex Male 2, 5. Color or race Negro 6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Marie Hickman 6. (c) Age of husband or wife if alive 41 years

7. Birth date of deceased September 14, 1901
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
44 5 25 hr. min.

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

10. Usual occupation City Refuge

11. Industry or business.....

MOTHER FATHER { 12. Name John Hickman

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

14. Maiden name Florence Luper

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

16. (a) Informant Marie Hickman

(b) Address 916 Chambers Street.

17. (a) Burial (b) Date thereof 3/6/46
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation National Cemetery

18. (a) Signature of funeral director C.W. Roberts

(b) Address 1416 N Taylor Ave

19. (a) MAR 5 1946 J. F. Breakman
(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
(If outside city or town limits, write "RURAL")
(d) Street No. 916 N. Taylor Ave. 11 9
(If rural, give location)
(e) Citizen of foreign country?..... (Yes or No)
If yes, name country.....

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 2
year 1946 hour 6 minute 30 A.M.

21. I hereby certify that I attended the deceased from Feb 25
1946 to March 2, 19 46
that I last saw him alive on March 25, 19 46
and that death occurred on the date and hour stated above.

Immediate cause of death..... Duration

mitral regurgitation?
Due to not known

Due to ✓
Other conditions none
(Include pregnancy within 3 months of death)

Major findings: Of operations none
Of autopsy none

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)..... none
(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) (a) Means of injury

23. Signature Dr. N. J. Miller (M. D. or other)
Address 8410 N Broadway Date signed 3/4/46
St Louis Mo

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

Amie White

Registered Apprentice No. *387*

working under my personal supervision.

Signed

Fulton G. Culkin

Licensed Embalmer No. *4198*

P. O. Address *4912 Mountain St*

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.

Registration District No. **318**Primary Registration District No. **1003**

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 *910 Chambers St.*
 (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 *Charles Heckman*3. (b) If veteran,
name war _____3. (c) Social Security
No. _____4. Sex *Male* 5. Color or race *Negro*
6. (a) Single, widowed, married, divorced *married*6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if
alive _____ year7. Birth date of deceased *9 14 1901*
(Month) (Day) (Year)8. AGE: Years Months Days If less than one day
44 5 18 hr. min.9. Birthplace _____
(City, town, or county) (State or foreign country)

10. Usual occupation _____

11. Industry or business _____

12. Name _____

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

16. (a) Informant _____

(b) Address _____

17. (a) _____ (b) Date thereof _____
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) _____ (b) *J. F. Bredek*
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

- (a) State _____ (b) County _____
 (c) City or town _____
 (If outside city or town limits, write "RURAL")
 (d) Street No. _____
 (If rural, give location)
 (e) Citizen of foreign country _____ (Yes or No)
 If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: month *March* day *21*
year *1946* hour _____ minute _____ 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 _____

Duration

Due to _____

Due to _____

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

Major findings:

Of operations _____

Of autopsy _____

PHYSICIAN

Underline
the cause to
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(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? _____ (c) Means of injury _____

23. Signature _____ (M. D. or other) _____

Address _____ Date signed _____

MAR 13 1946

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