No. 2
1/47
5-17-39

FEDERAL SECURITY AGENCY
National Office of Vital Statistics

MISSOURI DIVISION OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 35840

FILED OCT 24 1947

Registration District No. 318

Primary Registration District No. 1003

Registrar's No. 9337

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

1. PLACE OF DEATH:
(a) County MISSOURI
(b) City or town ST. LOUIS
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: MISSOURI BAPTIST HOSPITAL
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 4 DAYS (Specify whether
In this community
years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State MISSOURI (b) County
(c) City or town ST. LOUIS
(If outside city or town limits, write "RURAL")
(d) Street No. 3205 HARTFORD
(If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME JAMES B. HICKEY SR.
3. (b) If veteran, name war
3. (c) Social Security No. 492-24-4338
4. Sex MALE
5. Color or race WHITE
6. (a) Single, widowed, married, divorced Wid
6. (b) Name of husband or wife
6. (c) Age of husband or wife if alive years
7. Birth date of deceased SEPT. (Month) 11 (Day) 1867 (Year)

8. AGE: Years 80 Months 0 Days 26 If less than one day hr. min.

9. Birthplace PENNSYLVANIA (City, town, or county) (State or foreign country)
10. Usual occupation Retired Forgesmith
11. Industry or business Self.

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

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

16. (a) Informant JAMES B. HICKEY JR
(b) Address SAUM HOTEL, ST. LOUIS MO
17. (a) BURIAL (Burial, cremation, or removal) (b) Date thereof OCT. 10 1947 (Month) (Day) (Year)
(c) Place: burial or cremation CALVARY CEM.
18. (a) Signature of funeral director Thomas Kutis & Son
(b) Address 2906 GRAVOIS
19. (a) OCT 8 1947 (Date received local registrar) J. F. Bredeck (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month OCT. day 7
year 1947 hour 9 minute 20 P.M.

21. I hereby certify that I attended the deceased from Oct 3 1947, to Oct 7 1947
that I last saw him alive on Oct 7 1947
and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Broncho pneumonia	7 days
Due to	
Due to	
Other conditions: Arteriosclerotic heart disease (Include pregnancy within 3 months of death)	3

Major findings:
Of operations
Of autopsy

PHYSICIAN
Underline the cause of 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 Samuel B Grant (M. D. or other) MD
Address 114 N Taylor Ave Date signed 10/8/47

Jefferson City Printing Co.

(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 Leo J. Budde

Licensed Embalmer No. 3986

P. O. Address St. Louis, 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.

2B
3-45
1 X43880

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. N 5

Registration District No. 314 Primary Registration District No. 1003 Registrar's No. 7337

1. PLACE OF DEATH:

(a) County ST. LOUIS

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

(c) Name of hospital or institution:
(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 (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

3. (a) PRINT FULL NAME James B. Hickey Sr

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex M

5. Color or race W

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

6. (b) Name of husband or wife

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

7. Birth date of deceased Sept (Month) 11 (Day) 1866 (Year)

8. AGE: Years 80 Months 0 Days 26 If less than one day hr. min.

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

10. Usual occupation

11. Industry or business

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

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

16. (a) Informant
(b) Address

17. (a) (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)
(c) Place: burial or cremation

18. (a) Signature of funeral director
(b) Address

19. (a) (Date received local registrar) (b) J. F. Bredeck (Registrar's signature) NOV 3 1947

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct day
year 1947 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 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 (M. D. or other)
Address Date signed

SUPPLEMENTARY

5-35840