

MISSOURI DIVISION OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. 24372  
6582  
Registrar's No.

Registration District No. 318 Primary Registration District No. 100

1. PLACE OF DEATH:  
(a) County \_\_\_\_\_  
(b) City or town. ST. LOUIS  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution  
5630 Cote Brilliant  
(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 JOHN J. HICKEY  
3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_  
4. Sex MALE 5. Color or race WHITE  
6. (a) Single, widowed, married, divorced WIDOWER  
6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if  
alive \_\_\_\_\_ years  
7. Birth date of deceased FEB 17 - 1863  
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day  
85 5 8 hr. min.

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

10. Usual occupation IRELAND

11. Industry or business RETIRED

12. Name JOHN J. HICKEY

13. Birthplace IRELAND II  
(City, town, or county) (State or foreign country)

14. Maiden name MARY WASHINGTON  
(City, town, or county) (State or foreign country)

15. Birthplace IRELAND II  
(City, town, or county) (State or foreign country)

16. (a) Informant MRS FRED TINKHAM

(b) Address 5630 COTE BRILLIANT

17. (a) BURIAL (b) Date thereof 7-28-48  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation CALVARY

18. (a) Signature of funeral director Cullen Kelly

(b) Address 4386 Lindalee

19. (a) JUL 26 1948 (b) \_\_\_\_\_  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:  
(a) State MO (b) County WOO  
(c) City or town ST LOUIS  
(If outside city or town limits, write "RURAL")  
(d) Street No. 5630 COTE BRILLIANT  
6 (If rural, give location)  
(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION  
20. DATE OF DEATH: Month 25th day July  
year 1948 hour 11 minute 15 P. M.  
21. I hereby certify that I attended the deceased from Sept 1st  
1st to July 25, 1948  
and that death occurred on the date and hour stated above.

Immediate cause of death: Chronic Myocarditis 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? \_\_\_\_\_

While at work? \_\_\_\_\_ (Specify type of place) (e) Means of injury \_\_\_\_\_

23. Signature Clara B Kane (M. D. or other) \_\_\_\_\_

Address 206 Wallon Date signed 7-26-48

MOTHER FATHER

**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 James A. Lammers

Licensed Embalmer No. 4142

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.**