

#19634
DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED AUG 28 1948

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

27898
State File No. _____
Registrar's No. 7405

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

1. PLACE OF DEATH:

(a) County _____

(b) City or town St. Louis, Missouri

(c) Name of hospital or institution: St. Louis City Hospital-Max C. Starkloff
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 9 months (Specify whether years, months or days)

In this community _____

3. (a) PRINT FULL NAME EMMA KICKER

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 Feb. 9 1871
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
77 6 12 hr. min.

9. Birthplace St. Louis Missouri
(City, town, or county) (State or foreign country)

10. Usual occupation none

11. Industry or business _____

12. Name Henry J.W. Kicker

13. Birthplace Cape Girardeau Missouri
(City, town, or county) (State or foreign country)

14. Maiden name Minnie Henson

15. Birthplace St. Louis Missouri
(City, town, or county) (State or foreign country)

16. (a) Informant Minnie F. Pearson
(b) Address 5031 Kensington Ave.

17. (a) Burial (b) Date thereof Aug. 24 1948
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation St. Peter's Cemetery

18. (a) Signature of funeral director TRUTH CENTER MORTUARY
(b) Address 4024 Lindell Boulevard

19. (a) AUG 24 1948 (b) J. B. Braden
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County 000

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

(d) Street No. 5031 Kensington Ave., Memorial (If rural, give location)

(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug. day 21st
year 1948 hour 1 minute 58 P. M.

21. I hereby certify that I attended the deceased from 11/18/47
_____ 19 _____ to Aug. 21st 19 48
that I last saw her alive on Aug. 21st 19 48
and that death occurred on the date and hour stated above.

Immediate cause of death _____ Duration _____
Thrombosis Rt. Lenticulo-Substantia Arterio 8 days

Due to Hypertension & Arteriosclerosis

Due to _____

Other conditions (Include pregnancy within 3 months of death) 8/3

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? W.M. Linder (Specify type of place) (c) Means of injury M.D.

23. Signature W.M. Linder 1515 Lafayette (M. D. or other) _____
Address _____ Date signed 8/23/48

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.