FEDERAL SECURITY AGENCY
National Office of Vital Statistics

MISSOURI DIVISION OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 31092

FILED SEP 24 1948

Registration District No. 518

Primary Registration District No. 1005

Registrar's No. 8118

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

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 St. John's Hospital
(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 Missouri (b) County
(c) City or town St. Louis
(If outside city or town limits, write "RURAL")
(d) Street No. 5370 Wabada Ave.
(If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME Aloysius F. Hickman
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 married
6. (b) Name of husband or wife Clara G. Hickman
6. (c) Age of husband or wife if alive 58 years
7. Birth date of deceased April 6, 1884 (Month) (Day) (Year)

8. AGE: Years 64 Months 5 Days 8 If less than one day hr. min.

9. Birthplace (City, town, or county) Missouri (State or foreign country)
10. Usual occupation Operator
11. Industry or business Public Service Co.

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

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

16. (a) Informant Mrs. Clara G. Hickman
(b) Address 5370 Wabada Ave.
17. (a) burial (Burial, cremation, or removal) (b) Date thereof 9/16/48 (Month) (Day) (Year)
(c) Place: burial or cremation Laurel Hill Gardens
18. (a) Signature of funeral director Drehmann-Harral
(b) Address 1905 Union Blvd.
19. (a) (Date received local registrar) (b) (Registrar's signature)

SEP 16 1948

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept. day 14th year 1948 hour 5 minute 30 A.M.

21. I hereby certify that I attended the deceased from May, 1948, to Sept. 14, 1948, that I last saw him alive on Sept. 13, 1948, and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Cirrhosis of Liver (Laennec)	4.5 yrs.
Pulmonary Embolism	few mins.
Due to: Thrombo phlebitis st. lg.	3 mos.
Due to:	
Other conditions: None (Include pregnancy within 3 months of death)	
Major findings: Of operations: None	
Of autopsy: None	

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) No
(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 J. J. Hammond (M. D. or other) M.D.
Address 634 N. Grand Date signed 9/16/48

Jefferson City Printing Co.

(Licensed Embalmer's Statement on Reverse Side)

~~6901 Park Ave.~~

Dr. Hammond
at St Johns at
930 E. Wo

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 Warren A. Carver

Licensed Embalmer No. 3534

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.