

No. 300  
10.48

FILED FEB 14 1949

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

2796

State File No. ....

BIRTH NO. 49-004364 REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003 Registrar's No. 894

1. PLACE OF DEATH  
a. COUNTY

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).  
a. STATE Missouri b. COUNTY St. Louis

b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis

c. LENGTH OF STAY (in this place) 15 min  
c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis

d. FULL NAME OF HOSPITAL OR INSTITUTION Homer G. Phillips

d. STREET ADDRESS (If rural, give location) 2720 Clark

3. NAME OF DECEASED  
a. (First) b. (Middle) c. (Last)  
Infant - Hicks

4. DATE OF DEATH (Month) (Day) (Year)  
1 15 49

5. SEX Fem. 6. COLOR OR RACE Negro

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)

8. DATE OF BIRTH 1-15-49

9. AGE (In years last birthday) IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min. 15

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) Missouri

12. CITIZEN OF WHAT COUNTRY?

13a. FATHER'S NAME Arbrady Hicks

13b. MOTHER'S MAIDEN NAME Carrie Purifoy

14. NAME OF HUSBAND OR WIFE

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT'S SIGNATURE OR NAME ADDRESS  
Arthur M. Sherard 2601 N. Whittier

18. CAUSE OF DEATH  
Enter only one cause per line for (a), (b), and (c)

MEDICAL CERTIFICATION

INTERVAL BETWEEN ONSET AND DEATH

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH\* (a) Prematurity

\*This does not mean the mode of dying, such as heart failure, ashenia, etc. It means the disease, injury, or complication which caused death.

ANTECEDENT CAUSES DUE TO (b)

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS  
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?  
YES  NO

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK  NOT WHILE AT WORK

21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 1-15-, 19 49 to 1-15-, 19 49 that I last saw the deceased alive on 1-15-, 19 49, and that death occurred at 10:55am., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title)  
W. S. Anker, M.D.

23b. ADDRESS 2601 N. Whittier

23c. DATE SIGNED 1-19-49

24a. BURIAL, CREMATION, REMOVAL (Specify)

24b. DATE JAN 31 1949

24c. NAME OF CEMETERY OR CREMATORY Anatomical Soc.

24d. LOCATION (City, town, or county) (State)

DATE REC'D BY LOCAL REG. REGISTRAR'S SIGNATURE  
JAN 31 1949 J. B. Lester

25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS  
Rowland Mortuary Service

(Licensed Embalmer's Statement on Reverse Side)

4104 Manchester Ave.

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

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**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.....

..... Student Embalmer No. ....

working under my personal supervision.

Signed.....

Signed.....  
Student Embalmer

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.