

FILED JUL 18 1950

STANDARD CERTIFICATE OF DEATH

State File No. **24864**
5860
Registrar's No.

BIRTH NO. _____ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003**

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)	
b. CITY (If outside corporate limits, write RURAL and give township) SAINT LOUIS, MO.		a. STATE Illinois b. COUNTY Adams	
c. LENGTH OF STAY (in this place) 6 days		c. CITY (If outside corporate limits, write RURAL and give township) Quincy 8120	
d. FULL NAME OF HOSPITAL OR INSTITUTION BARNES HOSPITAL		d. STREET ADDRESS (If rural, give location) 317 $\frac{1}{2}$ Maiden Lane 8	

3. NAME OF DECEASED (Type or Print)			4. DATE OF DEATH (Month) (Day) (Year)		
a. (First) Milton	b. (Middle) James	c. (Last) Hicks	July 4 1950		
5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH April 27, 1921	9. AGE (In years last birthday) 29	IF UNDER 1 YEAR Months
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Truck Driver		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) San Antonio, Texas	
12. CITIZEN OF WHAT COUNTRY? U.S.					

13a. FATHER'S NAME Samuel Hicks	13b. MOTHER'S MAIDEN NAME Nellie Trump	14. NAME OF HUSBAND OR WIFE Virginia
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes World War II		16. SOCIAL SECURITY NO. Unknown
17. INFORMANT'S SIGNATURE OR NAME ADDRESS Samuel Hicks, Quincy, Ill.		

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH 1 yr
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Lymphosarcoma.		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ 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 <input checked="" type="checkbox"/> NO <input type="checkbox"/>
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 <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? 200.1

22. I hereby certify that I attended the deceased from 6-28, 1950, to 7-4, 1950, that I last saw the deceased alive on 7-4, 1950, and that death occurred at 12 noon m., from the causes and on the date stated above.

23a. SIGNATURE Eugene T. Standley, M.D.	(Degree or title)	23b. ADDRESS Barnes Hospital Saint Louis, Mo.	23c. DATE SIGNED 7/4/50
24a. BURIAL, CREMATION, REMOVAL (Specify) Removal	24b. DATE 7-5-50	24c. NAME OF CEMETERY OR CREMATORY Sunset	24d. LOCATION (City, town, or county) (State) Quincy, Ill.

DATE REC'D BY LOCAL REG. JUL 6 1950	REGISTRAR'S SIGNATURE J. B. Pascoe	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Albert H. Hoppe, 4700 Washington Blvd.
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(Licensed Embalmer's Statement on Reverse Side)

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

10

JUL 29 1950

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~~ by me

working under my personal supervision.

Student Embalmer No.....

Signed.....
Student Embalmer

Signed Lesly W Wilkinson

Licensed Embalmer No. 35175

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.