

FILED MAR 7 1955

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. 6216

Registrar's No. 1644

BIRTH NO. _____		REG. DIST. NO. <b>318</b>		PRIMARY REG. DIST. NO. <b>1003</b>		Registrar's No. <b>1644</b>			
1. PLACE OF DEATH a. COUNTY _____				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <b>Missouri</b> b. COUNTY _____					
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>St. Louis</b>		c. LENGTH OF STAY (In this place) <b>Life</b>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>St. Louis</b>					
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>St. Louis State 2</b>				d. STREET ADDRESS (If rural, give location) <b>2/3 7 5400 Arsenal Street</b>					
3. NAME OF DECEASED (Type or Print) a. (First) <b>Harry</b>		b. (Middle) _____		c. (Last) <b>Hicks</b>		4. DATE OF DEATH (Month) (Day) (Year) <b>February 15, 1955</b>			
5. SEX <b>Male 2</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>married /</b>	8. DATE OF BIRTH <b>3/18/1896</b>		9. AGE (In years last birthday) <b>58</b>	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HRS. Hour _____ Min. _____		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>none</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>none</b>		11. BIRTHPLACE (City and State or Foreign Country) <b>St. Louis 0</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A</b>			
13a. FATHER'S NAME <b>John Hicks</b>		13b. MOTHER'S MAIDEN NAME <b>Sarah Childs</b>		14. NAME OF HUSBAND OR WIFE <b>Helen Hicks</b>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>492-30-5475</b>		17. INFORMANT'S SIGNATURE OR NAME <b>Helen Hicks</b>		ADDRESS <b>-4641 Leduc</b>			
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	
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Carcinoma of rt. lung with compression of trachea</b>				DUPLICATE TO (b) _____				Sev. mos.	
*This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.				DUPLICATE 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 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) _____		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? <b>163x</b>					
22. I hereby certify that I attended the deceased from <b>7-1-54</b> , 19____, to <b>2-15</b> , 19 <b>55</b> , that I last saw the deceased alive on <b>2-15</b> , 19 <b>55</b> , and that death occurred at <b>6:00a.m.</b> , from the causes and on the date stated above.									
23a. SIGNATURE (Degree or title) <b>Clara Ayman M.D.</b>				23b. ADDRESS <b>5400 Arsenal Street</b>		23c. DATE SIGNED <b>2-16-55</b>			
24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>		24b. DATE <b>2/24/55</b>	24c. NAME OF CEMETERY OR CREMATORY <b>Oakdale Cemetery</b>		24d. LOCATION (City, town, or county) (State) <b>3900 Mt. Olive Mo.</b>				
DATE REC'D BY LOCAL REG. <b>FEB 21 1955</b>		REGISTRAR'S SIGNATURE <b>J. Earl Smith M.D.</b>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <b>Grant Johnson 4352 Wash. Blvd</b>					

m. J. B. (Licensed Embalmer's Statement on Reverse Side)

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

**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.

Student .....  
Student Embalmer

Signed

*F. A. Green*

Licensed Embalmer No. 2963

P. O. Address 4214 Blum

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.