

FILED FEB 17 1956

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

6632

State File No. \_\_\_\_\_

REG. DIST. NO. 318

1003

Registrar's No. 679

BIRTH NO. _____		REG. DIST. NO. 318		PRIMARY REG. DIST. NO. 1003		State File No. _____		Registrar's No. 679									
1. PLACE OF DEATH a. 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) _____ d. FULL NAME OF HOSPITAL OR INSTITUTION <b>Homer G. Phillips Hospital</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <b>Missouri</b> b. COUNTY _____ c. CITY OR TOWN <b>St. Louis</b> d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> e. STREET ADDRESS (If rural, give location) <b>3951 Labadie</b> 21076													
3. NAME OF DECEASED (Type or Print) a. (First) <b>Julius</b> b. (Middle) <b>C.</b> c. (Last) <b>Hickman</b>		4. DATE OF DEATH (Month) (Day) (Year) <b>1 16 56</b>		5. SEX <b>Male</b>		6. COLOR OR RACE <b>Negro</b>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>Widow</b>		8. DATE OF BIRTH <b>8-5-1886</b>		9. AGE (In years last birthday) <b>69</b>		10. IF UNDER 1 YEAR Months _____ Days _____		11. IF UNDER 6 HRS. Hours _____ Min. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Railroad</b>				11. BIRTHPLACE (City and State or Foreign Country) <b>Ohio</b>				12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>					
13a. FATHER'S NAME <b>Morris Hickman</b>				13b. MOTHER'S MAIDEN NAME <b>Mary ?</b>				14. NAME OF HUSBAND OR WIFE <b>Unknown</b>									
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. _____				17. INFORMANT'S SIGNATURE OR NAME <b>Julia E. Masley - Hospital Record</b>				ADDRESS _____					
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, asphyxia, etc. It means the disease, injury, or complication which caused death.				MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Bronchopneumonia</b> 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. <b>Metastatic Carcinoma of Urinary Bladder</b>								INTERVAL BETWEEN ONSET AND DEATH <b>Undt.</b>					
19a. DATE OF OPERATION _____				19b. MAJOR FINDINGS OF OPERATION <b>491x H</b>				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" 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) (Min.) _____		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>				21f. HOW DID INJURY OCCUR? _____											
22. I hereby certify that I attended the deceased from <b>12-14 1955</b> , to <b>1-16 1956</b> , that I last saw the deceased alive on <b>1-16 1956</b> , and that death occurred at <b>6:45 P. M.</b> , from the causes and on the date stated above.																	
23a. SIGNATURE <b>Merle Hereford</b> (Degree or title) <b>M.D.</b>				23b. ADDRESS <b>2601 N. Whittier</b>				23c. DATE SIGNED <b>1-18-56</b>									
24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>		24b. DATE <b>Jan 20/56</b>		24c. NAME OF CEMETERY OR CREMATORY _____				24d. LOCATION (City, town, or county) (State) <b>URBANA Ohio.</b>									
DATE REC'D BY LOCAL REG. <b>JAN 20 1956</b>				REGISTRAR'S SIGNATURE <b>J. Earl Smith M.D.</b>				25. FUNERAL DIRECTOR'S SIGNATURE <b>File Green 4214 Delmar</b> ADDRESS _____									

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..

Student.....  
Signature of Student Embalmer

Signed.....

*F. A. Green*

Licensed Embalmer No. *296*

P. O. Address *4214 Selma*

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.  
If this body is not embalmed, fact should be so stated above.