

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

FILED JUN 25 1956

STATE FILE NO. **21882**
REGISTRAR'S NO. **5758**

Registration District No. **318** Primary Registration District No. **1003**

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, give TOWNSHIP only) OR TOWN St. Louis		c. CITY OR TOWN St. Louis	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION ST. LOUIS CITY HOSP. # 1		d. STREET ADDRESS (If outside, give location) 20 3225 N. Florissant	
3. NAME OF DECEASED (Type or print) First THOMAS Middle HICKEY Last		4. DATE OF DEATH Month JUNE Day 15 Year 1956	
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 3rd, 1877
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Rail Road worker		10b. KIND OF BUSINESS OR INDUSTRY Rail Road	11. BIRTHPLACE (City and state or country) u.k.
13. FATHER'S NAME James Hickey		14. MOTHER'S MAIDEN NAME Mary Ann Carney	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 486-16-5593a	17. INFORMANT Address Mother Germaine 3225 North Florissant
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) chronic pneumonia Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) chronic pyelonephritis DUE TO (c) benign prostatic hypertrophy			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Hour 6:00 Month 9 Day 56 Year 56	610X		
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION	COUNTY STATE
21. I attended the deceased from 5-9-56 to 6-15-56 and last saw her him alive on 6-15-56 Death occurred at 6:00 P m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) Rhys D. Williams, M.D.		22b. ADDRESS 1515 Lafayette	22c. DATE SIGNED 6-16-56
23a. BURIAL, CREMATION, REMOVAL (Specify) burial	23b. DATE 6-18-1956	23c. NAME OF CEMETERY OR CREMATORY Calvary Cemetery	23d. LOCATION (City, town, or county) (State) St. Louis Missouri
24. FUNERAL DIRECTOR Arthur J. Donnelly	ADDRESS 3840 Lindell Blvd.	25. DATE RECD. BY LOCAL REG. JUN 18 1956	26. REGISTRAR'S SIGNATURE J. Earl Smith, M.D.

MEDICAL CERTIFICATION

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

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1-56

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related. Coroner cannot certify to a death due to natural causes.

STATEMENT BY LICENSED EMBALMER

DATE OF DEATH

PLACE

TIME

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 Francis Williams

Licensed Embalmer No. 350

P. O. Address 3840

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22-21-2

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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.