

FILED JAN 13 1958

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

45917  
STATE FILE NUMBER

Registration District No. 318

Primary Registration District No. 1003

Registrar's No. 12049

S. 300  
ev. 1-57

3

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MISSOURI</u> b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>ST LOUIS</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>ST. LOUIS</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>D.O.A CITY HOSP</u>		Length of stay in lb	d. STREET ADDRESS (If outside, give location) <u>4825 TERRACE</u> Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>MARIE</u> Middle <u>ANNA</u> Last <u>HICKMAN</u>			4. DATE OF DEATH Month <u>DEC</u> Day <u>13</u> Year <u>1957</u>
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>JAN 3 1904</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>COOK</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>BEVO MILL</u>	11. BIRTHPLACE (City and state or country) <u>MISSOURI</u>
13a. FATHER'S NAME <u>ROBERT WILL</u>		13b. MOTHER'S MAIDEN NAME <u>ANNA LATKE</u>	14. NAME OF HUSBAND OR WIFE <u>CHARLES HICKMAN</u>
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 Address <u>CHARLES HICKMAN 4825 TERRACE</u>
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>① Bronchial asthma</u>			INTERVAL BETWEEN ONSET AND DEATH <u>10 yrs +</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>② Hypertensive arteriosclerotic heart disease</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
DUE TO (c) _____			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>241x</u>			
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 _____ a.m. _____ p.m. Month, Day, Year _____		20d. INJURY OCCURRED WHILE AT <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 Death occurred at <u>10/26/57</u> to <u>12/13/57</u> and last saw her alive on <u>12/13/57</u> <u>5:05</u> p.m. on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <u>Robert Swarner, M.D.</u> (Degree or title)		22b. ADDRESS <u>818 Olive St St Louis Mo</u>	22c. DATE SIGNED <u>12/14/57</u>
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE <u>DEC 16 1957</u>	23c. NAME OF CEMETERY OR CREMATORY <u>MOUNT HOPE CRM</u>	23d. LOCATION (City, town, or county) (State) <u>ST. LOUIS MO</u>
24. FUNERAL DIRECTOR <u>Thomas Katis 2906 Gravia</u> ADDRESS		25. DATE RECD. BY LOCAL REG. <u>DEC 16 57</u>	26. REGISTRAR'S SIGNATURE <u>J. Earl Smith, M.D.</u> No. <u>9.13.</u>

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

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.

041781 0001 80

Paul Peterson, Embler,  
CP 1 4949

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 *Leaf Bullock* .....

Licensed Embalmer No. *3989* .....  
P. O. Address *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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.  
If this body is not embalmed, fact should be so stated above.