Health, & Welfare Public Service

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1-57

THE DIVISION OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

58-042529
STATE FILE NUMBER

FILED DEC 1 1958 Registration District No. 317 Primary Registration District No. 541 Registrar's No. 2896

1. PLACE OF DEATH
a. COUNTY St. Louis
b. CITY OR TOWN Clayton — Inside Limits Yes [X] No [ ]
c. FULL NAME OF HOSPITAL OR INSTITUTION (If NOT in hospital, give location) St. Louis Co. Hosp — Length of stay in 1b DOA

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Mo. b. COUNTY St. Louis
c. CITY OR TOWN Overland 4270 — Inside Limits Yes [X] No [ ]
d. STREET ADDRESS (If outside, give location) 2334 Gilrose — Reside on Farm Yes [ ] No [X]

3. NAME OF DECEASED (Type or print): First William — Middle E. — Last Kicker

4. DATE OF DEATH Month 11 Day 8 Year 1958

5. SEX Male

6. COLOR OR RACE White

7. MARRIED [ ] NEVER MARRIED [ ] WIDOWED [X] 2 DIVORCED [ ]

8. DATE OF BIRTH 1/23/1881 ~~1/23/1881~~

9. AGE (In years last birthday) 77 — IF UNDER 1 YEAR Months Days — IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired

10b. KIND OF BUSINESS OR INDUSTRY Title

11. BIRTHPLACE (City and state or country) St. Louis, Mo.

12. CITIZEN OF WHAT COUNTRY? USA

13a. FATHER'S NAME Charles H. Kicker

13b. MOTHER'S MAIDEN NAME Mary Hendel

14. NAME OF HUSBAND OR WIFE Deceased

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)

16. SOCIAL SECURITY NO. 715-10-5135

17. INFORMANT Joseph W. Fischer — Address 6138 Northgate

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

All diseases in Part I must be causally related.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Unknown natural cause — INTERVAL BETWEEN ONSET AND DEATH Unk
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b)
DUE TO (c) 7954
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 [ ] NO [X] 2

20a. ACCIDENT [ ] **SUICIDE** [ ] **HOMICIDE** [ ]

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 WORK [ ] NOT WHILE AT WORK [ ]

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 _____, to _____ and last saw her/him alive on _____
Death occurred at _____ m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) Herbert R. Domke, M.D. Local Registrar

22b. ADDRESS 801 S. Brentwood, Clayton, Mo.

22c. DATE SIGNED 11/20/58

23a. BURIAL, CREMATION, REMOVAL (Specify) Burial

23b. DATE 11-11-58

23c. NAME OF CEMETERY OR CREMATORY Valhalla Cemetery

23d. LOCATION (City, town, or county) St. Louis County, Mo. (State)

24. FUNERAL DIRECTOR [illegible]tmann F. Home — ADDRESS 0222 Lackland

25. DATE RECD. BY LOCAL REG. 11-10-58

26. REGISTRAR'S SIGNATURE Herbert R. Domke M.D.

(Licensed Embalmer's Statement on Reverse Side)

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 Al C. Ostmann

Licensed Embalmer No. 3478

P. O. Address .....

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.