THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-003063
STATE FILE NUMBER

FILED FEB 10 1959 Registration District No. ..... Primary Registration District No. ..... Registrar's No. 2 957

1. PLACE OF DEATH
a. COUNTY
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN: St. Louis Mo. — Inside Limits Yes ☐ No ☐
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION: St. Johns Hospital — Length of stay in Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Mo. b. COUNTY Phelps
c. CITY OR TOWN: St. James — Inside Limits Yes ☐ No ☒
d. STREET ADDRESS (If outside, give location): Route 2 — Reside on Farm Yes ☒ No ☐

3. NAME OF DECEASED (Type or print): First Robert Middle W. Last Hickey
4. DATE OF DEATH: Month 1 Day 23 Year 59
5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: Aug. 26, 1894
9. AGE (In years last birthday): 64 — IF UNDER 1 YEAR: Months 4 Days 27 — IF UNDER 24 HRS.: Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Salesman
10b. KIND OF BUSINESS OR INDUSTRY: Nursery
11. BIRTHPLACE (City and state or country): St. Louis Mo.
12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME: Robert Hickey
14. MOTHER'S MAIDEN NAME: Celine Vallet
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: Odilia Burkart Hickey — Address: Rt. 2 St James

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) Subarachnoid Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 4-5 hrs.
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) Cerebral Vascular Arteriosclerosis — unknown
DUE TO (c) Generalized Arteriosclerosis — unknown
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Hypertension & Left Sided Hemaplegia
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒
20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.): 330x
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 1-23-59, to 1-23-59 and last saw ~~her~~ him alive on 1-23-59
Death occurred at 6 p m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title): Samuel C. Bonney M.D.
22b. ADDRESS: Stricker Clinic St. James Mo
22c. DATE SIGNED: 1/26/59

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE: 1-28-58
23c. NAME OF CEMETERY OR CREMATORY: Calvary Cemetery
23d. LOCATION (City, town, or county) (State): St. Louis Mo.
24. FUNERAL DIRECTOR: Thomas J. Swain — ADDRESS: 1519 S. Grand.
25. DATE RECD. BY LOCAL REG.: JAN 28 '59
26. REGISTRAR'S SIGNATURE: Hart Smith, M.D.

(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

diseases in Part I must be casually related. Coroner cannot certify to a death due to natural causes.

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was e

by me, or by ....., Student Embalmer No.....

working under my personal supervision..

Student.....
Signature of Student Embalmer

Signed John S. Dem

Licensed Embalmer No. 419

P. O. Address St. Louis

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. 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.