

Health,
Vital
Public
Service

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-007218
STATE FILE NUMBER

FILED MAR 10 1959

Registration District No. _____ Primary Registration District No. _____ Registrar No. **1711**

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1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis		c. CITY OR TOWN St. Louis	
Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION St. Louis State Hosp.		Length of stay in 1b 6 yrs.	
d. STREET ADDRESS 7018 Pernod Ave.		(If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	

3. NAME OF DECEASED (Type or print)			4. DATE OF DEATH		
First Elizabeth	Middle Agnes	Last Hickey	Month Feb.	Day 14	Year 1959

5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 19, 1878	9. AGE (In years last birthday) 80	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	10b. KIND OF BUSINESS OR INDUSTRY Own home	11. BIRTHPLACE (City and state or country) St. Louis, Mo.	12. CITIZEN OF WHAT COUNTRY? U.S.A.
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13a. FATHER'S NAME Edward O'Brien	13b. MOTHER'S MAIDEN NAME Catherine Bode	14. NAME OF HUSBAND OR WIFE Robert B. Hickey
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15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No	16. SOCIAL SECURITY NO. None	17. INFORMANT Address Mrs. Jane Lacy 6945 Lindenwood Ave.
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Fracture of Right Hip.		INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) Generalized Arteriosclerosis	
	DUE TO (c) E903.7 44	

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)

20a. ACCIDENT <input checked="" 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.) Suffered in fall to floor at State
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20c. TIME OF INJURY Hour a.m. p.m. 1 26 59	Month, Day, Year January 26, 1959.
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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.) 137 Hosp.	20f. CITY, TOWN, OR LOCATION St. Louis Mo	COUNTY St. Louis	STATE Mo
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21. I attended the deceased from _____ and last saw her/him alive on _____
Death occurred at **9:30 P.** m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE Gabriel J. Taylor (Degree or title) Coroner	22b. ADDRESS 1300 Clark	22c. DATE SIGNED 2-17-59
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23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 2-18-1959	23c. NAME OF CEMETERY OR CREMATORY SS peter & Paul Cemetery	23d. LOCATION (City, town, or county) (State) St. Louis, Mo.
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24. FUNERAL DIRECTOR Hoffmeister Colonial Mortuary ADDRESS 626 Chippewa St. St. Louis, Mo.	25. DATE RECD. BY LOCAL REG. FEB 17 '59	26. REGISTRAR'S SIGNATURE Carl Smith, M.D.
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626 Chippewa St. St. Louis, Mo. (Licensed Embalmer's Statement on Reverse Side) *mjc*

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

All diseases in Part I must be causally related.

MEDICAL CERTIFICATION

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 *R. W. C. [Signature]*

Licensed Embalmer No. *4764*
P. O. Address *St. 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.