

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-011008
STATE FILE NUMBER

2.3022
Registrar's

Health,
Welfare
Public
Service

300
1-56
0 895
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.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

APR 6 1959 Registration District No. Primary Registration District No. Registrar's

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo. b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St Louis MO Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN St. Louis 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 LUKES HOSPITAL Length of stay in 1b		d. STREET ADDRESS (If outside, give location) 1031a Theobald Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First BABY Middle HICKS Last		4. DATE OF DEATH Month 3 Day 23 Year 59	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3 22 59
9. AGE (In years last birthday)		IF UNDER 1 YEAR Months 14 Days 35	IF UNDER 24 HRS. Hours 14 Min. 35
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) St Louis MO
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME DAVID ROBERT HICKS	
14. MOTHER'S MAIDEN NAME SHIRLEY ANN SULLIVAN		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no	
16. SOCIAL SECURITY NO. none		17. INFORMANT MOTHER Address 1031A THEOBALD ST LOUIS 15 MO	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Prematurity - Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) Respiratory atelectasis DUE TO (c) 762.5			INTERVAL BETWEEN ONSET AND DEATH 12 hrs.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Delivery of a premature pregnancy.			19. WAS AUTOPSY PERFORMED? YES <input checked="" 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 4 AM Month, Day, Year 3/23/59 a. m. p. m.			
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 2:22:59 , to 2:23:59 and last saw ^{her} him alive on 4 AM 2:23:59 m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) Joseph D. Okupe H.D.		22b. ADDRESS 3720 Washington Blvd.	
22c. DATE SIGNED 2-24-59			
23a. BURIAL, CREMATION, REMOVAL (Specify) removal		23b. DATE 3/25/59	
23c. NAME OF CEMETERY OR CREMATORY St. Johns Cemetery		23d. LOCATION (City, town, or county) (State) St. Louis County Mo.	
24. FUNERAL DIRECTOR Buchholz Mortuary 5967 W. Florissant ADDRESS		25. DATE RECD. BY LOCAL REG. MAR 25 '59	
26. REGISTRAR'S SIGNATURE Carl Smith, M.D.			

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.....
Not Embalmed
Walter B. Shalloo

Licensed Embalmer No. *15*

P. O. Address *A. Lau*

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.