URI DIVISION OF HEALTH – STANDARD CERTIFICATE OF DEATH 59-033901

FILED VS OCT 8 1959

Registration District No. _____ Primary Registration District No. _____ Registrar's No. 2 8963 STATE FILE NUMBER

ENDED

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 — Length of stay in 1b 5½ wks.

c. CITY OR TOWN St.Louis — Inside Limits Yes ☒ No ☐

c. FULL NAME OF HOSPITAL OR INSTITUTION (If NOT in hospital, give location) St.Anthony Hospital — Inside Limits Yes ☒ No ☐

d. STREET ADDRESS (If outside, give location) 1016a Geyer Ave. — Reside on Farm Yes ☐ No ☒

3. NAME OF DECEASED (Type or print) First Louise Middle Last Hicks

4. DATE OF DEATH Month Sept. Day 28, Year 1959

5. SEX Female

6. COLOR OR RACE White

7. Married ☐ Never Married ☐ Widowed ☒ Divorced ☐

8. DATE OF BIRTH 12/30/88

9. AGE (last birthday) 70 — IF UNDER 1 YEAR Months Days — IF UNDER 24 HR Hours Min.

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

10b. KIND OF BUSINESS OR INDUSTRY at home

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

12. CITIZEN OF WHAT COUNTRY U.S.A.

13a. FATHER'S NAME Henry Benning

13b. MOTHER'S MAIDEN NAME Josephine Maschek

14. NAME OF HUSBAND OR WIFE Lyman Hicks

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. unknown

17. INFORMANT Mrs. L. Hicks - Address 4501 Rosy Lane

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Encephalomalacia, Left Hemisphere — INTERVAL BETWEEN ONSET AND DEATH 1 month

Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.

DUE TO (b) Cerebral Apoplexy, Left with Regis — 8/20/59

DUE TO (c) Hemiplegia

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

PART III. If deceased was female was there a pregnancy in last 90 days. ☐ Yes ☒ No ☐ Unknown

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.)

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 3/12/55, to 9/28/59 and last saw her ~~him~~ alive on 9/28/59

Death occurred at 4:40 P.m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) Walter A Sunderland

22b. ADDRESS 4617 Dahlia Ave

22c. DATE SIGNED 9/29/59

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

23b. DATE Oct. 1, 1959

23c. NAME OF CEMETERY OR CREMATORY New Picker Cemetery

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

24. FUNERAL DIRECTOR WACKER-HELDERLE-ADDRESS 3634 Gravois Ave.

25. DATE RECD. BY LOCAL REG. SEP 29 59

26. REGISTRAR'S SIGNATURE Carl Smith, M.D.

(Licensed Embalmer's Statement on Reverse Side)

DOCUMENT

BY AFFIDAVIT OF

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 m

or by _____, Student Embalmer No._____

working under my personal supervision.

Student_____ Signed Frank J. Ryland Sr

Signature of Student Embalmer

Licensed Embalmer No. 2645

P. O. Address St Louis, Mo

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