SSOURI DIVISION OF HEALTH – STANDARD CERTIFICATE OF DEATH

-61-027342
STATE FILE NUMBER

AMENDED

FILED AUG 8 1961

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 7195

DATE AMENDED | INSTEAD OF | SHOULD READ | ITEM NO. | BY AFFIDAVIT OF | DOCUMENT

1. PLACE OF DEATH
a. COUNTY
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN: ST. LOUIS, MO.
Length of stay in 1b
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION: ST. LOUIS CITY HOSP. #1
Inside Limits: Yes ☐ No ☐

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MO
b. COUNTY
c. CITY OR TOWN: ST LOUIS
Inside Limits: Yes ☐ No ☐
d. STREET ADDRESS (If outside, give location): 2836 MISSOURI AVE
Reside on Farm: Yes ☐ No ☐

3. NAME OF DECEASED (Type or print): First THERESA Middle Last SICKING
4. DATE OF DEATH: Month AUGUST Day 1 Year 1961
5. SEX: FEMALE
6. COLOR OR RACE: WHITE
7. Married ☐ Never Married ☐ Widowed ☒ Divorced ☐
8. DATE OF BIRTH: OCT. 16 1879
9. AGE (last birthday): 81
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): HOUSE WORK
10b. KIND OF BUSINESS OR INDUSTRY: AT HOME
11. BIRTHPLACE (City and state or country): ILLINOIS
12. CITIZEN OF WHAT COUNTRY: U-S-A
13a. FATHER'S NAME: GEORGE EILERS
13b. MOTHER'S MAIDEN NAME: ANNA BAUMEYER
14. NAME OF HUSBAND OR WIFE: HERMAN SICKING
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.: NONE
17. INFORMANT: LUCILLE ROSE Address: 2836 MISSOURI AVE

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): Supportive Pyelonephritis
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b): Diabetes Mellitus
DUE TO (c): 260X
INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a): Possible Meningioma
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 JULY 23, 1961, to AUGUST 1, 1961 and last saw her/him alive on AUGUST 1, 1961
Death occurred at 8:18 p.m. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) John M. Greaney MD
22b. ADDRESS: 1515 LAFAYETTE AVE.
22c. DATE SIGNED: 8/1/61

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
23b. DATE: AUG 5. 1961
23c. NAME OF CEMETERY OR CREMATORY: ST. PETER + PAUL CEM.
23d. LOCATION (City, town, or county) (State): ST. LOUIS MO.

24. FUNERAL DIRECTOR: Thomas J Kutis ADDRESS: 2906 Gravois
25. DATE RECD. BY LOCAL REG.: AUG 3 1961
26. REGISTRAR'S SIGNATURE: Earl 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 _____ Signed _____

Signature of Student Embalmer

Licensed Embalmer No. 4347

P. O. Address 2906 Dr

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.