

**MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH**  
DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-62-020038

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. 310 Primary Registration District No. 3058 Registrar's No. 127 STATE FILE NUMBER

VS 300  
Rev. 4/59

1 0928

2 40132

3

4 0

5 1

6

7 0

8 1

9 773.5

10

11

12 1-0

13 4-0

DATE AMENDED

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

1. PLACE OF DEATH <u>23 1962</u> a. COUNTY <u>St Charles</u>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>mo</u> b. COUNTY <u>St Louis</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>St Charles</u>		Length of stay in 1b	c. CITY OR TOWN <u>Florissant</u>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>St Joseph's Hospt</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>227 St Eugene</u>
3. NAME OF DECEASED (Type or print) First Middle Last <u>John Wade Hickman</u>		4. DATE OF DEATH <u>May 12 1962</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>May 12 1962</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) <u>St. Charles, Mo</u>
13a. FATHER'S NAME <u>Stuart Wayne Hickman</u>		13b. MOTHER'S MAIDEN NAME <u>Joan Catherine Meyer</u>	14. NAME OF HUSBAND OR WIFE <u>None</u>
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	17. INFORMANT <u>Joan Hickman - (Mother)</u> Address
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory Distress Syndrome.</u> <u>(Hyaline Membrane Disease.)</u> DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH <u>4 1/2 hrs.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Prematurity</u>			PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
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 a.m. p.m. Month, Day, Year			
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 <u>5-12-62 10 AM</u> to <u>5-12 1:30 PM</u> and last saw <sup>her</sup> him alive on <u>5-12</u> . Death occurred at <u>1:30</u> p.m. on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <u>[Signature]</u> (Degree or title)		22b. ADDRESS <u>207 N 5th St Charles</u>	22c. DATE SIGNED <u>5/13/62</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	23b. DATE <u>5-14-62</u>	23c. NAME OF CEMETERY OR CREMATORY <u>CALVARY</u>	23d. LOCATION (City, town, or county) <u>St. Louis, Mo</u> (State)
24. FUNERAL DIRECTOR <u>THE FLORISSANT MORTUARY, Florissant Mo.</u> ADDRESS		25. DATE REC'D. BY LOCAL REG. <u>5/13/62</u>	26. REGISTRAR'S SIGNATURE <u>Maurella Wilson</u>

USE BLACK INK OR TYPEWRITER RIBBON

**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

*Gene A. Hutchins*

Licensed Embalmer No. 4966

P. O. Address FLORISSANT, 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.