

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

12657-62-048412  
REGISTRATION DISTRICT NO. 318  
PRIMARY REGISTRATION DISTRICT NO. 1003  
REGISTRAR'S NO. 1003  
STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

FILED JAN 10 1963

VS 300  
Rev. 4/59

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

USE BLACK INK OR TYPEWRITER RIBBON

ITEM NO. SHOULD READ

1. PLACE OF DEATH a. COUNTY <b>St. Louis</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Mo.</b> b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>St. Louis</b>		c. CITY OR TOWN <b>St. Louis</b>	
Length of stay in lb <b>DOA</b>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>St. John's Hospital</b>		d. STREET ADDRESS (If outside, give location) <b>3537 Connecticut</b>	
Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>KATHERINE E HICKOK</b>			4. DATE OF DEATH Month Day Year <b>December 31 1962</b>
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>11/17/1877</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>at home</b>		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (last birthday) <b>85</b>
11. BIRTHPLACE (City and state or country) <b>Hillsboro, Wisconsin</b>		12. CITIZEN OF WHAT COUNTRY <b>USA</b>	
13a. FATHER'S NAME <b>Godfrey F Miller</b>		13b. MOTHER'S MAIDEN NAME <b>Amelia Hoffmeister</b>	14. NAME OF HUSBAND OR WIFE <b>Thomas</b>
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no</b>		17. INFORMANT Address <b>Blanche Lang 338 Avenue H</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic Heart Disease</b>			INTERVAL BETWEEN ONSET AND DEATH <b>6 months</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <b>General Arteriosclerosis</b>			<b>5 years</b>
DUE TO (c) <b>420.0</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>Diaphragmatic Hernia</b>			PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" 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 s.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.) <b>Fth 1959</b>	20f. CITY, TOWN, OR LOCATION <b>Dec 1962</b>	COUNTY STATE
21. I attended the deceased from <b>12:30 P</b> to <b>Jan 12, 1962</b> and last saw her alive on <b>Jan 12, 1962</b>		Death occurred at _____ m on the date stated above, and to the best of my knowledge, from the causes stated.	
22a. SIGNATURE (Degree or title) <b>Walter W. Davis, M.D.</b>		22b. ADDRESS <b>539 N. Grand Ave</b>	22c. DATE SIGNED <b>1/2/63</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>removal</b>	23b. DATE <b>1/2/1963</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Mt. Vernon Cemetery</b>	23d. LOCATION (City, town, or county) (State) <b>Hillsboro, Wisconsin</b>
24. FUNERAL DIRECTOR ADDRESS <b>John L Ziegenhein &amp; Sons 7027 Gravois</b>		25. DATE RECD. BY LOCAL REG. <b>JAN 2 1963</b>	REGISTRAR'S SIGNATURE <b>Roald Smith, M.D.</b>

*ok. Cause of Death Report Corrected 1/2/63*

**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 Donald E. Ring

Licensed Embalmer No. 4863

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.