

Registration District No.

Primary Registration District No. **1000**

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH:

(a) County.....
 (b) City or town... **St. Louis.**
(If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution:
3678 Gravois Av. /
(If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution.....
(Specify whether
 In this community.....
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County.....
 (c) City or town... **St. Louis,**
(If outside city or town limits, write "RURAL")
 (d) Street No. **3678 Gravois Ave**
(If rural, give location)
 (e) Citizen of foreign country? **No** (Yes or No)
 If yes, name country.....

3. (a) PRINT FULL NAME **Joseph Sicking**

3. (b) If veteran, name war **No** 3. (c) Social Security No. **704 18 4590**

4. Sex **Male** 5. Color or race **White** 6. (a) Single, widowed, married, divorced **Married**

6. (b) Name of husband or wife **Veronica** 6. (c) Age of husband or wife if alive..... years

7. Birth date of deceased **Feb 19 1876**
(Month) (Day) (Year)

8. AGE: Years **67** Months **66** Days **10** 8 **25** If less than one day
hr. min.

9. Birthplace **St Louis Missouri.**
(City, town, or county) (State or foreign country)

10. Usual occupation **Retired Railroad Clerk**

11. Industry or business.....

12. Name **Frank Sicking**

13. Birthplace **St Louis Missouri.**
(City, town, or county) (State or foreign country)

14. Maiden name **Unknown**

15. Birthplace **Unknown**
(City, town, or county) (State or foreign country)

16. (a) Informant **Veronica Sicking.**

(b) Address **3678a Gravois Av.**

17. (a) **Burial** (b) Date thereof **1/18/43**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Old S.S. Peter & Paul**

18. (a) Signature of funeral director **Wm B. Maxwell**

(b) Address **1926 Allen Av.**

19. (a) **JAN 18 1943** **J. F. Preback**
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Jan. 14** day **14**
 year **1943** hour **9** minute **A.** M.

21. I hereby certify that I attended the deceased from **Nov. 13**, 1941 to **Jan 14**, 1943
 that I last saw him alive on **Jan 13**, 1943
 and that death occurred on the date and hour stated above.

Immediate cause of death **Myocardial Infarction**
Hypertension

Due to.....
 Due to.....

Other conditions **Acute Bronchitis**
(Include pregnancy within 3 months of death)

Major findings:
 Of operations.....
 Of autopsy.....

Duration **3 yrs**
10 days
 PHYSICIAN

22. If death was due to external causes, fill in the following:
 (a) Accident, suicide, or homicide (specify).....
 (b) Date of occurrence.....
 (c) Where did injury occur?.....
(City or town) (County) (State)
 (d) Did injury occur in or about home, on farm, in industrial place, in public place?
 While at work?.....
(Specify type of place) (e) Means of injury
 23. Signature **W. J. Sainsbury** (M. D.)
 Address **325 S. Lafayette** Date signed **1-15-43**

SEP 10 1943

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 me
....., Registered Apprentice No.
working under my personal supervision.

Signed D. M. Davis
Licensed Embalmer No. 3741
P. O. Address 1926 Allen

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 this body is not embalmed, fact should be so stated above.