S. No. 2
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WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED DEC 15 1944

Registration District No. 318

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

Primary Registration District No. 1003

State File No. 35795

Registrar's No. 10432

1. PLACE OF DEATH:

(a) County —

(b) City or town ST. Louis, Mo.
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: Barnes Hospital,
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 12 days (Specify whether
In this community years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Illinois (b) County Madison 999

(c) City or town Troy 11
(If outside city or town limits, write "RURAL")

(d) Street No. NR
(If rural, give location)

(e) Citizen of foreign country? (Yes or No)
If yes, name country 2

3. (a) PRINT FULL NAME LILA ANN DICKMAN

3. (b) If veteran, name war Nil

3. (c) Social Security No. None

4. Sex Female

5. Color or race White

6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife John O. Dickman

6. (c) Age of husband or wife if alive 44 years

7. Birth date of deceased April (Month) 22 (Day) 1900 (Year)

8. AGE: Years 44 Months 7 Days 12 If less than one day hr. min.

9. Birthplace Dahlgreen (City, town, or county) Illinois (State or foreign country)

10. Usual occupation Housewife

11. Industry or business

FATHER
12. Name Thomas Shipley
13. Birthplace Dahlgreen (City, town, or county) Illinois (State or foreign country)

MOTHER
14. Maiden name Orphia McReynolds
15. Birthplace Hamilton Co. (City, town, or county) Illinois (State or foreign country)

16. (a) Informant John O. Dickman
(b) Address Troy, Ill.

17. (a) Removal (Burial, cremation, or removal) (b) Date thereof 12-5-44 (Month) (Day) (Year)
(c) Place: burial or cremation Troy, Illinois

18. (a) Signature of funeral director Edwards Funeral Home
(b) Address 47 Troy, Illinois Blvd.

19. (a) DEC 7 1944 (Date received local registrar) (b) J. F. Bredeck (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec. day 4
year 1944 hour 2 minute 45 P. M.

21. I hereby certify that I attended the deceased from Nov. 22, 1944, to Dec. 4, 1944; that I last saw her alive on Dec. 4, 1944; and that death occurred on the date and hour stated above.

Immediate cause of death Surgical Shock

Due to Hemorrhage

Due to Sarcomatous degeneration of myomata of the uterus

Other conditions Diabetes mellitus
(Include pregnancy within 3 months of death)

Major findings:
Of operations Nodular enlargement of the uterus.
Of autopsy Same.

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

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?
(Specify type of place)
While at work? (e) Means of injury 0

23. Signature F. W. Vieaux (M. D. or other)
Address Barnes Hospital Date signed 12/4/44

(Licensed Embalmer's Statement on Reverse Side)

10438

10438

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.....

....., Registered Apprentice No.....,

working under my personal supervision.

Signed.....

Licensed Embalmer No.....

P. O. Address.....

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.