

FILED JAN 7 1947

Registration District No. **318**

Primary Registration District No. **1003**

Registrar's No. **11239**

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:
5637 Prange St.
(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 **000**
(c) City or town **St. Louis**
(If outside city or town limits, write "RURAL") **7 1/2**
(d) Street No. **5637 Prange St.**
(If rural, give location) **0**
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME **Edward P. Pickel**

3. (b) If veteran, name war **No** 3. (c) Social Security No. **718-18-7471**

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

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

7. Birth date of deceased **August 1 1883**
(Month) (Day) (Year)

8. AGE: Years **63** Months **4** Days **27** If less than one day hr. min.

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

10. Usual occupation **District Mgr.**

11. Industry or business **Fruit Growers Express Co**

12. Name **Peter Pickel**

13. Birthplace **Germany**
(City, town, or county) (State or foreign country)

14. Maiden name **Augusta Obermeyer**

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

16. (a) Informant **Mrs. Clara Pickel**

(b) Address **5637 Prange St.**

17. (a) **Burial** (b) Date thereof **12-31-46**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Park Lawn Cemetery**

18. (a) Signature of funeral director **Cullinane Bros.**

(b) Address **3320 N. Kingshighway Blvd.**

19. (a) **DEC 30 1946** (b) **J. F. Brueck**
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Dec.** day **28** year **1946** hour **3** minute **45** P. M.

21. I hereby certify that I attended the deceased from **Dec 28** 19**46** to **Dec 28 46** 19**46** that I last saw **him** alive on **Dec 28** 19**46** and that death occurred on the date and hour stated above.

Immediate cause of death: **Stomach**
Due to **Malnutrition (Carcinoma)**
Due to **Stomach & Liver - Primary**

Other conditions: _____
(Include pregnancy within 3 months of death)

Major findings: _____
Of operations _____
Of autopsy _____

Duration **12-28-46**
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? _____

While at work? _____ (Specify exact place) Means of injury _____

23. Signature **J. F. Brueck** (M. D. or other) **MD**
Address **5637 Prange St.** Date signed **12/28/46**

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

MOTHER FATHER

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 Fred Trick

Licensed Embalmer No. 3186

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