

STANDARD CERTIFICATE OF DEATH

20779

FILED JUL 15 1949

State File No.

BIRTH NO. ... REG. DIST. NO. ... **318** ... Registrar's No. **5783**

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE MISSOURI b. COUNTY MAPLE AVE	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN ST. LOUIS		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN ST. LOUIS	
d. FULL NAME OF HOSPITAL OR INSTITUTION CITY SANITARIUM		d. STREET ADDRESS (If rural, give location) 5240 MAPLE	

3. NAME OF DECEASED (Type or Print)	a. (First) MARY	b. (Middle) JANE	c. (Last) BICK	4. DATE OF DEATH (Month) (Day) (Year) July 2, 1949
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5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) WIDOW	8. DATE OF BIRTH JULY 18-1889	9. AGE (In years) (last birthday) (Months) (Days) (Hours) (Min.) 59	12. CITIZEN OF WHAT COUNTRY? MO
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) PATIENT		11. BIRTHPLACE (State or foreign country) MO		12. CITIZEN OF WHAT COUNTRY? MO	

13a. FATHER'S NAME WILLIAM FOX	13b. MOTHER'S MAIDEN NAME MARY DAVITT	14. NAME OF HUSBAND OR WIFE ARTHUR BICK
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S SIGNATURE OR NAME Glenn Bick	ADDRESS -5377 Cabanellas
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18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, ashenia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH*(a) Cerebral Hemorrhage-Post operative ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. (Bilateral Prefrontal Lobotomy for Psychosis 5/24/49) DUE TO (b) DUE TO (c) II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		INTERVAL BETWEEN ONSET AND DEATH
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19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
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21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) 832
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (m.)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? 331X
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22. I hereby certify that I attended the deceased from Apr. 6, 1947, to July 2, 1949, that I last saw the deceased alive on July 2, 1949, and that death occurred at 11:32 AM., from the causes and on the date stated above.

23a. SIGNATURE Jack R. Hidelman	(Degree or title)	23b. ADDRESS 5400 Arsenal St.	23c. DATE SIGNED 7/3/49
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24a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	24b. DATE JULY 5-1949	24c. NAME OF CEMETERY OR CREMATORY CALVARY CEM	24d. LOCATION (City, town, or county) (State) ST. LOUIS MO
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DATE REC'D BY LOCAL REGISTRAR'S SIGNATURE JUL 4 1949 J. B. Lasser	25. FUNERAL DIRECTOR'S SIGNATURE L. Muller	ADDRESS Und Co 5165 DELMAR BL
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

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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
Student Embalmer

Signed

H. G. Farnon

Licensed Embalmer No. 3384

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.