

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **14107**  
REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003** Registrar's No. **3106**

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|---|--|---|--|--|--|--|--|
| BIRTH NO. _____   |  | REG. DIST. NO. <b>318</b>               |  | PRIMARY REG. DIST. NO. <b>1003</b>   |  | Registrar's No. <b>3106</b>  |  |
| 1. PLACE OF DEATH<br>a. COUNTY _____  |  |   |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>a. STATE <b>Illinois</b> b. COUNTY <b>Madison</b> |  |  |  |
| b. CITY (If outside corporate limits, write RURAL and give township) <b>St. Louis</b> |  | c. LENGTH OF STAY (in this place) _____ |  | c. CITY OR TOWN <b>Granite City</b>  |  | d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input type="checkbox"/> |  |
| d. FULL NAME OF HOSPITAL OR INSTITUTION <b>BARNES HOSPITAL</b>                        |  |   |  | e. STREET ADDRESS (If rural, give location) <b>1630 Maple Ave. 812<sup>o</sup> 8</b>   |  |  |  |

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|---|--|--|---|--|--|
| 3. NAME OF DECEASED<br>a. (First) <b>William Lee</b> b. (Middle) <b>Sikes</b> c. (Last) <b>Sikes</b>              |  |  | 4. DATE OF DEATH (Month) (Day) (Year) <b>April 4 54</b> |  |  |
| 5. SEX <b>Male</b>  |  | 6. COLOR OR RACE <b>White</b>                    |   | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>Married</b>  |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Farmer</b> |  | 10b. KIND OF BUSINESS OR INDUSTRY <b>Farming</b> |   | 8. DATE OF BIRTH <b>July 11, 1882</b>  |  |
|   |  |  |   | 9. AGE (In years last birthday) <b>71</b> IF UNDER 1 YEAR: Months _____ Days _____ IF UNDER 1 HR. Hours _____ Min. _____ |  |
|   |  |  |   | 11. BIRTHPLACE (City and State or Foreign Country) <b>Madison Co., Ill.</b>  |  |
|   |  |  |   | 12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>   |  |

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|--|--|--|--|---|--|
| 13a. FATHER'S NAME <b>William Henry Sikes</b>  |  | 13b. MOTHER'S MAIDEN NAME <b>Sophonra Cook</b> |  | 14. NAME OF HUSBAND OR WIFE <b>Anna Lee Sikes</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> |  | 16. SOCIAL SECURITY NO. <b>456-18-4036</b>     |  | 17. INFORMANT'S SIGNATURE OR NAME ADDRESS <b>Anna Lee Sikes, Granite City, Ill.</b> |  |

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| 18. CAUSE OF DEATH<br>Enter only one cause per line for (a), (b), and (c)<br><br><i>*This does not mean the mode of dying, such as heart failure, ashenia, etc. It means the disease, injury, or complication which caused death.</i> |  | MEDICAL CERTIFICATION<br>I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Mediastinitis</b><br><br>ANTECEDENT CAUSES<br><b>Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.</b><br>DUE TO (b) <b>Perforation of Esophagus</b><br><br>DUE TO (c) _____<br><br>II. OTHER SIGNIFICANT CONDITIONS<br><i>Conditions contributing to the death but not related to the disease or condition causing death.</i> |  |  | INTERVAL BETWEEN ONSET AND DEATH<br><b>3 days</b> |
|---|--|--|--|--|---|

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|---|--|--|--|--|--|
| 19a. DATE OF OPERATION _____                          |  | 19b. MAJOR FINDINGS OF OPERATION _____   |  | 20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 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) _____                            |  |
| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) _____ |  | 21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> |  | 21f. HOW DID INJURY OCCUR? _____   |  |

22. I hereby certify that I attended the deceased from **March 22, 1954**, to **April 4, 1954**, that I last saw the deceased alive on **April 4, 1954**, and that death occurred at **5:25 p.m.**, from the causes and on the date stated above.

|  |  |                                     |  |                                     |  |
|--|--|-------------------------------------|--|-------------------------------------|--|
| 23a. SIGNATURE <b>C. J. Vermillion, M.D.</b> (Degree or title) <b>MD</b> |  | 23b. ADDRESS <b>BARNES HOSPITAL</b> |  | 23c. DATE SIGNED <b>April 5, 54</b> |  |
|--|--|-------------------------------------|--|-------------------------------------|--|

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|--|--|-------------------------|--|--|--|---|--|
| 24a. BURIAL, CREMATION, REMOVAL <b>Removal</b> |  | 24b. DATE <b>4-7-54</b> |  | 24c. NAME OF CEMETERY OR CREMATORY <b>Oak Grove Cemetery</b> |  | 24d. LOCATION (City, town, or county) (State) <b>Fredericktown, Mo.</b> |  |
|--|--|-------------------------|--|--|--|---|--|

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| DATE REC'D BY LOCAL REGISTRAR'S SIGNATURE <b>APR 6 1954</b> <b>J. Earl Smith, M.D.</b> |  | 25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <b>Albert H. Hoppe, 4700 Washington Blvd.</b> |  |
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(Licensed Embalmer's Statement on Reverse Side)

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.....  
Signature of Student Embalmer

Signed *John S. Penne*.....

Licensed Embalmer No. *914*.....

P. O. Address *St. Louis*.....

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.