

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH.

State File No. **35247**  
Registrator's No. **9293**

FILED NOV 15 1955

REG. DIST. NO. **318**

PRIMARY REG. DIST. NO. **1003**

No. 300  
10-48

BIRTH NO. _____		REG. DIST. NO. <b>318</b>		PRIMARY REG. DIST. NO. <b>1003</b>		State File No. <b>35247</b>		Registrator's No. <b>9293</b>	
1. PLACE OF DEATH a. COUNTY _____				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <b>Mo</b> b. COUNTY _____					
b. CITY (If outside corporate limits, write RURAL and give town) OR TOWN <b>St Louis</b>		c. LENGTH OF STAY (in this place) <b>10 days</b>		c. CITY OR TOWN <b>St Louis</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>St Anthony Hospital</b>				e. STREET ADDRESS (If rural, give location) <b>2 5432 Blow</b>					
3. NAME OF DECEASED (Type or Print) a. (First) <b>Edward</b>			b. (Middle) <b>N</b>		c. (Last) <b>Vickers</b>		4. DATE OF DEATH (Month) (Day) (Year) <b>Oct 23, 1955</b>		
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>married</b>		8. DATE OF BIRTH <b>Jan 1, 1881</b>		9. AGE (In years last birthday) <b>74</b>	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HRS. Hours _____ Mins. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>Farmer</b>		11. BIRTHPLACE (City and State or Foreign Country) <b>New Liberty Ill.</b>			12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13a. FATHER'S NAME <b>Alex Vickers</b>			13b. MOTHER'S MAIDEN NAME <b>Mina Meely</b>			14. NAME OF HUSBAND OR WIFE <b>Essie Vickers</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>none</b>		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <b>Russell H Vickers 9300 McKenzie</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))		MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION (DIRECTLY LEADING TO DEATH)* (a) _____		DUE TO (b) <b>Cerebral Ischemic Hypertensive Cardiovascular disease</b>						<b>3 days</b>	
ANTECEDENT CAUSES (Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.)		DUE TO (c) <b>Hypocholesterolemia</b>						<b>1 1/2 yrs</b>	
* This does not mean the mode of dying, such as heart failure, ashenia, etc. It means the disease, injury, or complication which caused death.		11. OTHER SIGNIFICANT CONDITIONS <b>Fract of L hip</b>						<b>3 days</b>	
19a. DATE OF OPERATION <b>NO</b>		19b. MAJOR FINDINGS OF OPERATION <b>E 903.0</b>				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT (Specify) <b>Accident</b>		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>home</b>		21c. (CITY, TOWN, OR TOWNSHIP) <b>St Louis</b> (COUNTY) <b>Mo</b> (STATE) <b>Mo</b>					
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) <b>Oct 13, 1955</b>		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21f. HOW DID INJURY OCCUR? <b>Slipped &amp; fell</b>					
22. I hereby certify that I attended the deceased from <b>10-13</b> , 19 <b>55</b> , to <b>10-23</b> , 19 <b>55</b> , that I last saw the deceased alive on <b>10-23</b> , 19 <b>55</b> , and that death occurred at <b>5:15P</b> m., from the causes and on the date stated above.									
23a. SIGNATURE <b>R. J. Norman</b> (Degree or title) <b>M.D.</b>				23b. ADDRESS <b>9505 Gravois</b>			23c. DATE SIGNED <b>10-24-55</b>		
24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>		24b. DATE <b>10/26/55</b>	24c. NAME OF CEMETERY OR CREMATORY <b>St Paul Churchyard</b>		24d. LOCATION (City, town, or county) (State) <b>St Louis County Mo</b>				
DATE REC'D BY LOCAL REG. <b>OCT 25 1955</b>		REGISTRAR'S SIGNATURE <b>Carl Smith M.D.</b>			25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <b>L Ziegenhein &amp; Sons 7027 Gravois</b>				

WRITE PLAINLY--USING UNFADING BLACK INK--MAKE A PERMANENT RECORD

**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 *Donald E. Berry*.....

Licensed Embalmer No. *4863*.....

P. O. Address *2027 S. ...*.....

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.