Health, & Welfare Public Service

5. 300
. 1-56

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be casually related. Coroner cannot certify to a death due to natural causes.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

FILED APR 15 1957

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

STATE FILE NUMBER 10879

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 2891

1. PLACE OF DEATH
a. COUNTY
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN: St. Louis — Inside Limits Yes [X] No [ ]
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION: Lutheran Hosp — Length of stay in Hospital: 10 Days

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Missouri b. COUNTY
c. CITY OR TOWN: St. Louis — Inside Limits Yes [X] No [ ]
d. STREET ADDRESS (If outside, give location): 3443a Michigan — Reside on Farm Yes [ ] No [X]

3. NAME OF DECEASED (Type or print): First: Wilson Middle: P Last: Pickle
4. DATE OF DEATH: Month: Mar Day: 23 Year: 1957
5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]
8. DATE OF BIRTH: July 22, 1880
9. AGE (In years last birthday): 76 — IF UNDER 1 YEAR: Months, Days — IF UNDER 24 HRS.: Hours, Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Carpenter
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (City and state or country): Illinois
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: Henry Pickle
14. MOTHER'S MAIDEN NAME: Clara Wells
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: None
17. INFORMANT: Roy Pickle Address: 3443a Michigan

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Encephalomalacia; — INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b) Cerebral Thrombosis;
DUE TO (c) Ruptured Esophagus.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
332X
19. WAS AUTOPSY PERFORMED? YES [X] NO [ ]

20a. ACCIDENT [ ] SUICIDE [ ] HOMICIDE [ ]
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year
20d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
20f. CITY, TOWN, OR LOCATION COUNTY STATE

21. I attended the deceased from _____, to _____ and last saw her/him alive on _____
Death occurred at 805 A m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title): [signature]
22b. ADDRESS: [illegible]
22c. DATE SIGNED: 3/25/57

22a. BURIAL, CREMATION, REMOVAL (Specify): Removal
22b. DATE: 3-25-57
23c. NAME OF CEMETERY OR CREMATORY: Sugar Camp
23d. LOCATION (City, town, or county) (State): Belle Rive Illinois

24. FUNERAL DIRECTOR: Albert H. Hoppe ADDRESS: 4700 Washington
25. DATE RECD. BY LOCAL REG.: MAR 25 '57
26. REGISTRAR'S SIGNATURE: Earl Smith MD

(Licensed Embalmer's Statement on Reverse Side)

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was emba

by me, or by ....., Student Embalmer No.....

working under my personal supervision..

Student.....
Signature of Student Embalmer

Signed Stanley H. Dixo

Licensed Embalmer No. 419

P. O. Address St. L

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Fa
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.