

FILED MAY 27 1957

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **19292**  
**4748**

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003** Registrar's No. \_\_\_\_\_

1. PLACE OF DEATH  
a. COUNTY \_\_\_\_\_

b. CITY (If outside corporate limits, write RURAL and give town) **St. Louis**  
c. LENGTH OF STAY (in this place) **22 days**  
c. CITY OR TOWN **Memphis**  
d. Is Residence within limits of a city or incorporated town? Yes  No

d. FULL NAME OF HOSPITAL OR INSTITUTION **Frisco Employees' Hospital Assn**  
e. STREET ADDRESS (If rural, give location) **2197 Frisco Ave**

3. NAME OF DECEASED  
a. (First) **John** b. (Middle) **Irving** c. (Last) **Sickles**  
4. DATE OF DEATH (Month) (Day) (Year) **May 19 1957**

5. SEX **Male** 6. COLOR OR RACE **White** 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) **Married** 8. DATE OF BIRTH **Apr 20, 1895** 9. AGE (in years last birthday) **62** 10. UNDER 1 YEAR Months **1** 11. UNDER 1 MO. Days **1** 12. HOURS **1** 13. MIN. **1**

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) **Railroad Clerk**  
10b. KIND OF BUSINESS OR INDUSTRY **Rail Road**  
11. BIRTHPLACE (City and State or Foreign Country) **Reynoldsville, Mo**  
12. CITIZEN OF WHAT COUNTRY? **USA**

13a. FATHER'S NAME **John W.** 13b. MOTHER'S MAIDEN NAME **Sarah Jane Sartin** 14. NAME OF HUSBAND OR WIFE **Velma Foster Sickles**

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) **Yes** (If yes, give war or dates of service) **World War I**  
16. SOCIAL SECURITY NO. \_\_\_\_\_  
17. INFORMANT'S SIGNATURE OR NAME **Wife** ADDRESS **Same address**

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, asphyxia, etc. It means the disease, injury, or complication which caused death.  
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH\* (a) **Adenocarcinoma of Transverse Colon and generalized Carcinomatosis**  
INTERVAL BETWEEN ONSET AND DEATH **19 days**  
ANTECEDENT CAUSES **Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.**  
DUE TO (b) \_\_\_\_\_  
DUE TO (c) \_\_\_\_\_  
II. OTHER SIGNIFICANT CONDITIONS **153x**  
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION **3-12-1957**  
19b. MAJOR FINDINGS OF OPERATION **Adenocarcinoma of Colon & metastases in liver**  
20. AUTOPSY? YES  NO

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  NOT WHILE AT WORK   
21f. HOW DID INJURY OCCUR? \_\_\_\_\_

22. I hereby certify that I attended the deceased from **4-27**, 19**57**, to **5-19**, 19**57**, that I last saw the deceased alive on **5-18**, 19**57**, and that death occurred at **12:55** p.m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) **Memmond Miller M.D.** 23b. ADDRESS **4960 Laclede Ave** 23c. DATE SIGNED **5-19-57**

24a. BURIAL, CREMATION, REMOVAL (Specify) **Removal** 24b. DATE **5-19-57** 24c. NAME OF CEMETERY OR CREMATORY **Local** 24d. LOCATION (City, town, or county) (State) **Memphis Tenn**

DATE REC'D BY LOCAL REG. **MAY 20 1957** REGISTRAR'S SIGNATURE **Carl Smith M.D.** 25. FUNERAL DIRECTOR'S SIGNATURE **Albert H. Hoppe** ADDRESS **4700 Washington**

**Int. Ho Spital 5-7-57 to 4-7-57 put & returned 4-27-57 to 5-19-57**

WRITE PLAINLY—USING UNFAADING BLACK INK—MAKE A PERMANENT RECORD

8011

MAY 18 1957

JAN 24 1958

APR 2 1958

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 *Stanley H. Dixon*

Licensed Embalmer No. *419*

P. O. Address *St. L.*

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.

notarized: .....