

Health,
Welfare
Public
Service

300
1-56

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

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

19443

FILED JUN 14 1957

318

1003

STATE FILE NUMBER
5233

Registration District No. Primary Registration District No. Registrar's No.

1. PLACE OF DEATH a. COUNTY				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Illinois</u> b. COUNTY <u>St. Clair</u>					
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>ST. LOUIS, MO.</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN <u>East St. Louis 8120</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>			
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>04 BARNES HOSPITAL</u>			Length of stay in 1b <u>2 Days</u>		d. STREET ADDRESS (If outside, give location) <u>32 14 D, S. Gompers Homes</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First <u>FRANK</u> Middle <u>NMN</u> Last <u>WICKS</u>				4. DATE OF DEATH Month <u>MAY</u> Day <u>31</u> Year <u>1957</u>					
5. SEX <u>Male 2</u>		6. COLOR OR RACE <u>Negro</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>July 1, 1897</u>		9. AGE (In years last birthday) <u>59</u> IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Unemployed laborer</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Packing Industry</u>		11. BIRTHPLACE (City and state or country) <u>Corinth, Mississippi</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		
13. FATHER'S NAME <u>Sam Wicks</u>				14. MOTHER'S MAIDEN NAME <u>Unknown</u>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO</u>			16. SOCIAL SECURITY NO. <u>Unknown</u>		17. INFORMANT <u>14 D. Samuel Gompers Homes East St. Louis, Illinois</u>			17. INFORMANT <u>Sarah Wicks,</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>MYOCARDIAL INFARCTION</u>							INTERVAL BETWEEN ONSET AND DEATH		
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>ARTERIOSCLEROTIC HEART DISEASE</u>							3 YRS.		
DUE TO (c)									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>DIABETES MELLITUS 12 YRS.</u>							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>260X</u>						
20c. TIME OF INJURY Hour - Month, Day, Year a. m. p. m.									
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		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 <u>MARCH 7, 1957</u> to <u>MAY 31, 1957</u> and last saw her alive on <u>MAY 31, 1957</u> Death occurred at <u>2:40 P.M.</u> on the date stated above; and to the best of my knowledge, from the causes stated.									
22a. SIGNATURE (Degree or title) <u>E. Venullian, M.D.</u>				22b. ADDRESS <u>BARNES HOSPITAL</u>			22c. DATE SIGNED <u>6/1/57</u>		
23a. BURIAL, CREMATION, RECOVERY (Specify)		23b. DATE <u>June 4, 1957</u>		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town, or county) (State) <u>East St. Louis, Illinois</u>			
24. FUNERAL DIRECTOR ADDRESS <u>Marshall Funeral Home - E. St. Louis, Ill.</u>				25. DATE RECD. BY LOCAL REG. <u>JUN 4 '57</u>		26. REGISTRAR'S SIGNATURE <u>J. Carl Smith M.D.</u> S.P.			

(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

JUN 20 1951

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 *Thomas M. Hobbs*

Licensed Embalmer No. *44*
P. O. Address *2205 Main Calhoun St.*

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