

**FEDERAL BUREAU OF INVESTIGATION
U.S. DEPARTMENT OF JUSTICE
FEDERAL BUREAU OF INVESTIGATION
U.S. DEPARTMENT OF JUSTICE**

U.S. DEPARTMENT OF HEALTH - STANDARD CERTIFICATE OF DEATH
FILED VS SEP 22 1959

59-034186

STATE FILE NUMBER

2 8258

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>MISSOURI</u> b. COUNTY _____	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>ST. LOUIS</u>		Length of stay in 1b <u>LIFE</u>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>CITY-HOSPITAL #1.</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
d. STREET ADDRESS <u>16024 NO. 17TH ST.</u>		(If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>MATHILDA _____ PICKEL</u>			4. DATE OF DEATH Month Day Year <u>SEPT. 6TH 1959</u>
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>1-7-1863</u>
9. AGE (last birthday) <u>96 YRS.</u>		IF UNDER 1 YEAR Months Days	IF UNDER 24 HR Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSE-WORK</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>HOME</u>	11. BIRTHPLACE (City and state or country) <u>ST. LOUIS-MO.</u>
12. CITIZEN OF WHAT COUNTRY <u>U. S. A.</u>		13a. FATHER'S NAME <u>HENRY-HAMBECKER</u>	
13b. MOTHER'S MAIDEN NAME <u>SOPHIE-PIEPER</u>		14. NAME OF HUSBAND OR WIFE <u>JOSEPH-JOHN-PICKEL <DECD.></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>NONE</u>	
17. INFORMANT <u>ADELE-PICKEL: 10336-OLD-OLIVE-ST. RD.</u>		Address <u>CREVE-COEUR, MO.</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>Fracture of hip; Generalized arterio sclerosis</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.) DUE TO (b) <u>suffered in fall down steps in home</u> DUE TO (c) <u>on July 13, 1959 - Accident</u>			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)			PART III. If deceased was female was there a pregnancy in last 90 days. <u>90.0 21</u> <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20a. ACCIDENT <input checked="" 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>fall down steps</u>	
20c. TIME OF INJURY Hour _____ a.m. _____ p.m. <u>7-10-59</u>	20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>2nd home</u>	20f. CITY, TOWN, OR LOCATION <u>St. Louis</u>
20g. COUNTY <u>Missouri</u>		20h. STATE	
21. I attended the deceased from _____ to _____ and last saw her/him alive on _____. Death occurred at _____ on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree of title) <u>Joseph M. Zuss</u>		22b. ADDRESS <u>1300 Clark</u>	22c. DATE SIGNED <u>9/5/59</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE <u>SEPT. 9-1959</u>	23c. NAME OF CEMETERY OR CREMATORY <u>CALVARY-CEMATERY</u>	23d. LOCATION (City, town, or county) <u>ST. LOUIS MO.</u>
24. FUNERAL DIRECTOR <u>Rockland Und. Co.</u>	ADDRESS <u>1827-HOGAN-ST.</u>	25. DATE RECD. BY LOCAL REG. <u>SEP 8'59</u>	26. REGISTRAR'S SIGNATURE <u>Earl Smith, M.D.</u>

DOCUMENT

MEDICAL CERTIFICATION

BY APPOINTMENT OF

mja

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by _____
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed Stanley H. Dixon

Licensed Embalmer No. 4193

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.