

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN ST. LOUIS Mo		c. CITY OR TOWN ST. LOUIS	
Length of stay in 1b		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 3426 - IOWA		d. STREET ADDRESS (If outside, give location) 3426 - IOWA	
Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First PHILIP Middle A. Last SCHICKER			4. DATE OF DEATH Month 11 Day 13 Year 1961			
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5. SEX MALE	6. COLOR OR RACE WHITE	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH JAN. 27 1901	9. AGE (last birthday) 60	IF UNDER 1 YEAR Months	IF UNDER 24 HR Days	Hours	Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) DENTAL TECHNICIAN	10b. KIND OF BUSINESS OR INDUSTRY GRAND DENTAL LAB.	11. BIRTHPLACE (City and state or country) ST. LOUIS Mo	12. CITIZEN OF WHAT COUNTRY U. S. A.
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13a. FATHER'S NAME ADOLPH SCHICKER	13b. MOTHER'S MAIDEN NAME JOHANNA REIS	14. NAME OF HUSBAND OR WIFE MABEL SCHICKER
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No	17. INFORMANT Address MABEL SCHICKER 3426 - IOWA
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:		INTERVAL BETWEEN ONSET AND DEATH 3 yrs. 2 wks. —
IMMEDIATE CAUSE (a) (1) Carcinoma of Prostate		
DUE TO (b) Chronic myocarditis		
DUE TO (c) Cardiac acute failure		

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) 177X		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
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19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" 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.)
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20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year

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 St	COUNTY	STATE
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21. I attended the deceased from Sept 10 - 1958 to Nov 13 1961 and last saw him alive on Nov 10 - 1961 Death occurred at 8 P.M. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) Everett J. Jabony M.D.	22b. ADDRESS 607 20 Grand Blvd St Louis Mo	22c. DATE SIGNED 11-5-61
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23a. BURIAL, CREMATION, REMOVAL (Specify) REMOVAL	23b. DATE Nov. 16 1961	23c. NAME OF CEMETERY OR CREMATORY MT. HOPE CEM.	23d. LOCATION (City, town, or county) ST. LOUIS CO. Mo.
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Funeral Director Thomas Kuter 2906 Gravier	25. DATE RECD. BY LOCAL REG. NOV 16 1961	26. REGISTRAR'S SIGNATURE Loard Smith, M.D.
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DATE AMENDED

INSTEAD OF

DOCUMENT

MEDICAL CERTIFICATION

SHOULD READ

BY AFFIDAVIT OF

ITEM NO.

Ms. PCC

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 *Coody H. Thompson*

Licensed Embalmer No. *24869*

P. O. Address *Clinton 5, Mo.*

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.