

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

MISSOURI STATE BOARD OF HEALTH  
BUREAU OF VITAL STATISTICS  
CERTIFICATE OF DEATH

PLACE OF DEATH  
County Haute Lo  
Township Union  
or  
Village Conway  
or  
City \_\_\_\_\_ (NO. \_\_\_\_\_ St. \_\_\_\_\_ Ward \_\_\_\_\_)

Registration District No. 448 File No. 20576  
Primary Registration District No. 4266 Registered No. 8

(If death occurred in a hospital or institution, give its NAME instead of street and number)

FULL NAME Lena Hicks

PERSONAL AND STATISTICAL PARTICULARS

SEX female COLOR OR RACE white SINGLE MARRIED WIDOWED OR DIVORCED (Write the word)

DATE OF BIRTH Jan 17 - 1910  
(Month) (Day) (Year)

AGE 5 yrs. 21 mos. 21 ds. If LESS than 1 day, \_\_\_ hrs. or \_\_\_ min.?

OCCUPATION (a) Trade, profession, or particular kind of work \_\_\_\_\_ (b) General nature of industry, business, or establishment in which employed (or employer) \_\_\_\_\_

BIRTHPLACE St Louis Mo  
(City or town, State or foreign country)

PARENTS NAME OF FATHER Robert Lee Hicks BIRTHPLACE OF FATHER Dallas Co Mo MAIDEN NAME OF MOTHER Portia Gann BIRTHPLACE OF MOTHER Dallas Co Mo

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) R. L. Hicks (ADDRESS) Conway Mo

Filed July 10 1910 H. R. Summers REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH July 8 1910  
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from July 7, 1910, to July 8, 1910, that I last saw her alive on July 8, 9:30 a.m., 1910, and that death occurred, on the date stated above, at 9:15 a.m. The CAUSE OF DEATH\* was as follows:

meningitis  
11913  
790

(Duration) \_\_\_ yrs. \_\_\_ mos. 3 ds. Contributory Dian Kora (SECONDARY) (Duration) \_\_\_ yrs. \_\_\_ mos. 3 ds.

(Signed) S. W. Covance M. D. July 8 1910 (Address) Conway Mo

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS) At place of death \_\_\_ yrs. \_\_\_ mos. \_\_\_ ds. In the State \_\_\_ yrs. \_\_\_ mos. \_\_\_ ds. Where was disease contracted if not at place of death? Former or usual residence \_\_\_\_\_

PLACE OF BURIAL OR REMOVAL Conway Mo DATE OF BURIAL July 8 1910 UNDERTAKER W. Hanson ADDRESS Conway Mo

