

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

PLACE OF DEATH

County Boone
Township Cepher
or
Village Columbia
or
City Columbia (NO. _____ St. _____ Ward _____)

Registration District No. 71 File No. 13441
Primary Registration District No. 5110A Registered No. 14

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

FULL NAME Thomas H. Hickman

PERSONAL AND STATISTICAL PARTICULARS

SEX Male COLOR OR RACE white SINGLE MARRIED WIDOWED OR DIVORCED (Mark the word) married

DATE OF BIRTH Aug 15, 1887
(Month) (Day) (Year)

AGE 73 yrs. 8 mos. 8 ds. If LESS than 1 day, ___ hrs. or ___ min.?

OCCUPATION (a) Trade, profession, or particular kind of work Farmer
(b) General nature of industry, business, or establishment in which employed (or employer) 1-02

BIRTHPLACE (City or town, State or foreign country) Boone Co Mo

PARENTS
NAME OF FATHER David H. Hickman
BIRTHPLACE OF FATHER (City or town, State or foreign country) Bourbon Co Ky
MAIDEN NAME OF MOTHER C. A. Bryan
BIRTHPLACE OF MOTHER (City or town, State or foreign country) Bourbon Co Ky

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) T. B. Hickman

(ADDRESS) Columbia Mo

Filed X 1914 REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH April 23, 1914
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from April 15, 1914, to April 22, 1914, that I last saw him alive on April 22, 1914,

and that death occurred, on the date stated above, at 7:30 a.m.

The CAUSE OF DEATH* was as follows:
Pneumonia
11A
109A

Length of Residence (Duration) Eight days yrs. ___ mos. ___ ds.

Contributory Lagrippe (Secondary) 3 weeks yrs. ___ mos. ___ ds.

(Signed) J. E. Thornton M. D. (Address) Columbia 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 Columbia Cemetery DATE OF BURIAL April 24, 1914

UNDERTAKER W. A. Roberts ADDRESS Columbia Mo

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.

Revised United States Standard Certificate of Death

[Approved by U. S. Census and American Public Health
Association]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Composer*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritonacum*, etc., *Carcinoma*, *Sar-*

coma, etc., of _____ (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.*; *Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL septicaemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)



County Boone Registration District No. 71 File No. 13441
 Township Cedar or _____ Primary Registration District No. 51109 Registered No. 14
 Village _____ or _____ City _____ (No. _____ St. _____ Ward _____)

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

FULL NAME Thomas A. Hickman

PERSONAL AND STATISTICAL PARTICULARS

SEX male COLOR OR RACE white SINGLE MARRIED WIDOWED OR DIVORCED (Write the word) married
 DATE OF BIRTH Aug. 15, 1887
 (Month) (Day) (Year)
 AGE 73 yrs. 8 mos. 8 ds. If LESS than 1 day, hrs. or min. 2
 OCCUPATION (a) Trade, profession, or particular kind of work Farm
 (b) General nature of industry, business, or establishment in which employed (or employer) _____

BIRTHPLACE (City or town, State or foreign country) Boone Co., Mo.
 NAME OF FATHER David W. Hickman
 BIRTHPLACE OF FATHER (City or town, State or foreign country) Bourbon Co., Ky.
 MAIDEN NAME OF MOTHER S. A. Bryan
 BIRTHPLACE OF MOTHER (City or town, State or foreign country) Bourbon Co., Ky.

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
 (Informant) J. B. Hickman
 (ADDRESS) Columbia Mo.

Filed X ap/24 1911 X At Nichols
 REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH April 23, 1911
 (Month) (Day) (Year)
 I HEREBY CERTIFY, that I attended deceased from April 15, 1911, to April 23, 1911,
 that I last saw him alive on April 22, 1911,
 and that death occurred, on the date stated above, at 7:30 a.m.
 The CAUSE OF DEATH* was as follows:

Pneumonia
 (Duration) Eight days yrs. _____ mos. _____ ds.
 Contributory La Grippe
 (SECONDARY) 3 weeks (Duration) yrs. _____ mos. _____ ds.
 (Signed) J. C. Thornton M. D.
Apr. 24, 1911 (Address) Columbia Mo.
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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 Columbia Cemetery DATE OF BURIAL Apr. 24, 1911
 UNDERTAKER D. A. Roberett ADDRESS Columbia Mo.

Revised United States Standard Certificate of Death

[Approved by U. S. Census and American Public Health
Association]

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