

JAN 28 1929

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

Do not use this space.

42240

1. PLACE OF DEATH

County St. Clair  
Township Osceola  
City Osceola (No. ....)

Registration District No. 765  
Primary Registration District No. 4460

File No. ....  
Registered No. 2425 St. .... Ward)

2. FULL NAME

Mrs Mary E. Hicks

(a) Residence. No. .... St., .... Ward. ....  
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 62 yrs. mos. da. How long in U.S., if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

female

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)

Widow

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF

Thos D Hicks

6. DATE OF BIRTH (MONTH, DAY AND YEAR)

Jan 25 1849

7. AGE

79 YEARS

1 MONTHS

4 DAYS

IF LESS than 1 day, .... hrs. or .... min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work

housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN)

St. Clair Co. Mo.

(STATE OR COUNTRY)

10. NAME OF FATHER

Jack Strain

11. BIRTHPLACE OF FATHER (CITY OR TOWN)

(STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER

Ediga Preston

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)

(STATE OR COUNTRY)

Tennessee

14. INFORMANT

Mollie E. Shrewsbury  
(Address) Osceola Mo

15. FILED

12/30 1928  
R. Seavers  
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR)

Dec 29th 1928

17.

I HEREBY CERTIFY, That I attended deceased from Dec 20th, 1928, to Dec 29th, 1928 (that I last saw him alive on Dec 29th 1928, and that death occurred, on the date stated above, at 3 A.M.

THE CAUSE OF DEATH\* WAS AS FOLLOWS:

11 A  
Hypostatic Pneumonia  
11 B

CONTRIBUTORY (SECONDARY)

Influenza

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH

DID AN OPERATION PRECEDE DEATH? DATE OF .....  
WAS THERE AN AUTOPSY? .....

WHAT TEST CONFIRMED DIAGNOSIS

(Signed) G. D. Dalghish, M. D.

12/30, 1928 (Address) Osceola Mo

\*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL

Osceola Mo

DATE OF BURIAL

12-30 1928

20. UNDERTAKER

Hull & Butcher Smith

ADDRESS

Osceola



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

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

**1. PLACE OF DEATH**

County St. Clair  
Township Osceola  
City Osceola (No. .... St. .... Ward)

Registration District No. 765  
Primary Registration District No. 4460

File No. ....  
Registered No. 23

**2. FULL NAME**

Mrs Mary E. Hicks

(a) Residence. No. .... St. .... Ward. ....  
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

**PERSONAL AND STATISTICAL PARTICULARS**

**MEDICAL CERTIFICATE OF DEATH**

3. SEX 7 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) W

16. DATE OF DEATH (MONTH, DAY AND YEAR) Dec 29 1928

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OR (OR) WIFE OF

17. I HEREBY CERTIFY That I attended deceased from ..... 19....., 19..... that I last saw h..... alive on....., 19....., and that death occurred, on the date stated above at..... m.

6. DATE OF BIRTH (MONTH, DAY AND YEAR)

THE CAUSE OF DEATH WAS AS FOLLOWS:

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, .... hrs. or .... min.

8. OCCUPATION OF DECEASED  
(a) Trade, profession, or particular kind of work ..... (duration) ..... yrs. .... mos. .... ds.  
(b) General nature of industry, business, or establishment in which employed (or employer) ..... (duration) ..... yrs. .... mos. .... ds.  
(c) Name of employer

CONTRIBUTORY (SECONDARY) ..... (duration) ..... yrs. .... mos. .... ds.

9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

18. WHERE WAS DISEASE CONTRACTED  
IF NOT AT PLACE OF DEATH.....

10. NAME OF FATHER

DID AN OPERATION PRECEDE DEATH..... DATE OF.....

11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) Don't know

WAS THERE AN AUTOPSY.....

12. MAIDEN NAME OF MOTHER  
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY)

WHAT TEST CONFIRMED DIAGNOSIS.....

(Signed)....., M. D.  
, 19 (Address)

\*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

14. INFORMANT (Address)

19. PLACE OF BURIAL, CREMATION, OR REMOVAL DATE OF BURIAL

15. FILED 9/29 19 29 Osceola REGISTRAR

20. UNDERTAKER ADDRESS

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW

SUPPLEMENTARY

S-42240