

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

Do not use this space.

33140

**1. PLACE OF DEATH**

County Calloway  
Township Fulton  
City Fulton (No. \_\_\_\_\_)

Registration District No. 104  
Primary Registration District No. 3008

File No. \_\_\_\_\_  
Registered No. 224  
St. \_\_\_\_\_ Ward \_\_\_\_\_

**2. FULL NAME**

(a) Residence. No. 2901st Fulton 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**

**3. SEX**

Female

**4. COLOR OR RACE**

White

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

Infant

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

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

Oct. 28 - 1929

**7. AGE**

YEARS

MONTHS

DAYS

If LESS than 1 day, 1 hrs. 36 min.

**8. OCCUPATION OF DECEASED**

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

an infant

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

(c) Name of employer

**9. BIRTHPLACE (CITY OR TOWN)**

Fulton Mo

(STATE OR COUNTRY)

**10. NAME OF FATHER**

Kenneth Wickell

**11. BIRTHPLACE OF FATHER (CITY OR TOWN)**

Salisbury Md

(STATE OR COUNTRY)

**12. MAIDEN NAME OF MOTHER**

Geneva Mae Maupin

**13. BIRTHPLACE OF MOTHER (CITY OR TOWN)**

Catonsville Mo

(STATE OR COUNTRY)

**14.**

INFORMANT  
(Address)

Mrs W. E. Maupin  
Fulton Mo

**15.**

FILED

Oct 29 1929

R. H. Green  
REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

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

Oct 28 1929

**17.**

I HEREBY CERTIFY, That I attended deceased from on date of birth Oct 28, 1929, to death Oct 28, 1929 that I last saw her alive on Oct 28, 1929, and that death occurred, on the date stated above, at 12:40 P. M.

**THE CAUSE OF DEATH\* WAS AS FOLLOWS:**

Premature birth  
159 / 6 1/2

(duration) yrs. mos. ds.

**CONTRIBUTORY (SECONDARY)**

(duration) yrs. mos. ds.

**18. WHERE WAS DISEASE CONTRACTED**

**IF NOT AT PLACE OF DEATH**

DID AN OPERATION PRECEDE DEATH? No DATE OF \_\_\_\_\_

WAS THERE AN AUTOPSY? no

**WHAT TEST CONFIRMED DIAGNOSIS?**

(Signed) R. H. Green M. D.

Oct. 29, 1929 (Address)

Fulton 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**

**DATE OF BURIAL**

19

**20. UNDERTAKER**

**ADDRESS**

N. B.—Every item of information should be fully supplied. AGE should be stated EXACTLY. PHYSICIAN'S name and CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

14  
73348

1953  
NOV 1953

1111  
1111

11

**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 Callaway

Registration District No. 104

File No. ....

Township Fulton

Primary Registration District No. 3008

Registered No. 224

City Fulton (No. ....) St. .... Ward)

**2. FULL NAME**

Dorothy Ann Wickell

(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**

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

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

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

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

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

**PARENTS**  
10. NAME OF FATHER  
11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY)  
12. MAIDEN NAME OF MOTHER  
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY)

14. INFORMANT (Address)

15. Oct 29, 1929 R. N. Crews REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) Oct 28 1929

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

THE CAUSE OF DEATH\* WAS AS FOLLOWS:

..... (duration) ..... yrs. .... mos. .... ds.

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

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)....., 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.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL DATE OF BURIAL  
Mount Carmel Cem Oct 29, 1929

20. UNDERTAKER ADDRESS  
Herndon Taylor Fulton

**SUPPLEMENTARY**

N. B.—Every item of information should be carefully supplied. AGE should be given EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. REGISTRARS SHALL NOT RECEIVE A ... FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW

5-33140