

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

Do not use this space.

8570

1. PLACE OF DEATH

County Vernon Registration District No. 875
 Township Washington Primary Registration District No. 6162
 City (No. 4) St. _____ Ward _____

File No. _____
 Registered No. 68

2. FULL NAME

Gas Robert Hickey
 (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 m 4. COLOR OR RACE w 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) married

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

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

7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min.
75 ✓

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work farmer 1933
 (b) General nature of industry, business, or establishment in which employed (or employer) 107
 (c) Name of employer _____

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

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

14. INFORMANT State Hosp Records
 (Address) Nevada Mo

15. FILE 3-11-31 E.P. King REGISTRAR

2 MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Feb 16 1931

17. I HEREBY CERTIFY, That I attended deceased from May 13 1931 to Feb 16 1931 that I last saw alive on Feb 16 1931 and that death occurred, on the date stated above, at _____ m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Broncho Pneumonia (duration) _____ yrs. _____ mos. 5 ds.

CONTRIBUTORY Chronic Myocarditis (SECONDARY) (duration) 17 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? Yes
 WHAT TEST CONFIRMED DIAGNOSIS? Chinise Lab
 (Signed) E.H. Coan M. D.

7-16-1931 (Address) Nevada 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 State Hosp # 3 DATE OF BURIAL 2/17 1931

20. UNDERTAKER Allen V Hays ADDRESS Nevada Mo.

Chy to Taylor 103

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.

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