

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

Do not use this space.

31700

1. PLACE OF DEATH

County Lafayette Registration District No. 45-4
Township Dover Davis Primary Registration District No. 5624B
City _____ (No. _____) St. _____ Ward _____

File No. _____
Registered No. 10

2. FULL NAME

William Franklin Hickman

(a) Residence No. _____ St. _____ Ward _____
(Usual place of abode)

Length of residence in city or town where death occurred 44 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds. (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Married

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Oct. 19-1862

7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min.
68 10 12

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Farmer
(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) Lafayette Co., Mo.

PARENTS

10. NAME OF FATHER William Hickman

11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) Lafayette Co.; Mo.

12. MAIDEN NAME OF MOTHER Mary G. Smelser

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) Lafayette Co.; Mo.

14.

INFORMANT L. L. Hickman
(Address) Alma; Mo.

15.

FILED 9-2-1931 J. G. W. Fischer
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Sept. 1st-1931

17. I HEREBY CERTIFY, That I attended deceased from 11-21, 1920, to 9-1, 1931, that I last saw him alive on 8-31, 1931, and that death occurred, on the date stated above, at 6 AM m.

THE CAUSE OF DEATH* WAS AS FOLLOWS

Cerebral Hemorrhage

875
CONTRIBUTORY (SECONDARY) 875 (duration) 1 yrs. 9 mos. 20 ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH _____

8 DID AN OPERATION PRECEDE DEATH? _____ DATE OF _____

WAS THERE AN AUTOPSY? _____

WHAT TEST CONFIRMED DIAGNOSIS _____

(Signed) J. M. Hoover, M. D.

9-2-1931 (Address) Alma 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 Calvary Cemetery-Corder

DATE OF BURIAL

9-3-1931

20. UNDERTAKER

ADDRESS Higginsville
Mo.

Hooper & Hoover

WRITE PLAINLY, WITH UNFADING INK---THIS IS A PERMANENT RECORD

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.

OCT 24 1931

