

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

Do not use this space.

33429

1. PLACE OF DEATH

County Waver
Township Bridgeport
City Waver (No.)

Registration District No. 861
Primary Registration District No. 6172

File No.
Registered No. 40
St. Ward)

2. FULL NAME Earnest Gottlieb Sickman

(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. da. How long in U. S., if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

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

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Feb 28 - 1852

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.
79 0 18

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) S
(c) Name of employer

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

10. NAME OF FATHER Ferdinand Sickman

11. BIRTHPLACE OF FATHER (CITY OR TOWN) Germany
(STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER Anna Menkhoff

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Germany
(STATE OR COUNTRY)

14. INFORMANT F. H. Sickman
(Address) Waver Mo

15. FILED Oct 10, 1931 A. W. Gehring
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Sept 18 1931

17. I HEREBY CERTIFY, That I attended deceased from Sept 12, 1931 to Sept 18, 1931 that I last saw him alive on Sept 17, 1931, and that death occurred, on the date stated above, at 8:21 a.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Apoplexy
(duration) ... yrs. ... mos. 3 ... ds.
CONTRIBUTORY (SECONDARY) Chromyocarditis
(duration) 3 yrs. ... mos. ... ds.

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH no

DID AN OPERATION PRECEDE DEATH? no DATE OF c

WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS Clinical
(Signed) H. C. Johnson, M. D.

(Address) Waver 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 Smith Creek M E Church DATE OF BURIAL 9/21 1931

20. UNDERTAKER F. W. Gehring ADDRESS Waver Mo

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.

NOV 28 1931

