

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.

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

Do not use this space.

JAN 14 1935

44717

1. PLACE OF DEATH

County.....
Township.....
City.....

Registration District No. 731
Primary Registration District No. 1003

File No.....
Registered No. 11831
St. _____ Ward _____

2. FULL NAME

(a) Residence, No. 4457
(Usual place of abode) _____ 15 Ward.

(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 <i>M</i>	4. COLOR OR RACE <i>w.</i>	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) <i>Widowed</i>		
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF <i>Ann Hickman</i>				
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) <i>Aug 29 1877</i>				
7. AGE	YEARS <i>57</i>	MONTHS <i>3</i>	DAYS <i>16</i>	OR LESS than 1 day, hrs. or min.
OCCUPATION	8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. <i>Die Cutter</i>			
	9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.			
	10. Date deceased last worked at this occupation (month and year)..... (f. Total time (years) spent in this occupation.....)			
12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <i>Virginia</i>				
FATHER	13. NAME <i>Mrs B. Hickman</i>			
	14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <i>Virginia</i>			
MOTHER	15. MAIDEN NAME <i>Unknown</i>			
	16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <i>Virginia</i>			
17. INFORMANT (ADDRESS) <i>Dr. J. P. Kent</i>				
18. BURIAL CREMATION, OR REMOVAL PLACE DATE <i>St. Nicholas Bur Dec 15 1934</i>				
19. UNDERTAKER (ADDRESS) <i>Craig Undertaking Co</i>				
20. FILED <i>10 13 1935</i> <i>J. F. Bredeck</i> Registrar.				

MEDICAL CERTIFICATE OF DEATH

1. DATE OF DEATH (MONTH, DAY, AND YEAR) *12/13 1934*

2. I HEREBY CERTIFY, That I attended deceased from *12/11 1934* to *12/13 1934*

I last saw him alive on *12/13 1934* Death is said to have occurred on the date stated above, at *12:30 pm*.

The principal cause of death and related causes of importance were as follows:

Carcinoma of Stomach

Other contributory causes of importance:
None

Name of operation *Exploratory Lap at Frinton* Date of *12/13*

What test confirmed diagnosis? Was there an autopsy? *Yes*

23. If death was due to external causes (violence), fill in also the following:
Accident, suicide, or homicide? Date of injury 19.....
Where did injury occur? (Specify city or town, county, and State)
Specify whether injury occurred in industry, in home, or in public place.

Manner of injury.....
Nature of injury.....

24. Was disease or injury in any way related to occupation of deceased?
If so, specify.....
(Signed) *R. B. Lurgan*, M. D.
(Address) *St. Nicholas Bur*

