

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

38996
Do not use this space.

1. PLACE OF DEATH
Buchanan

(a) County Buchanan Registration District No. 85

(b) Township Primary Registration District No. 1001

(c) City St. Joseph (d) Street No. Mo. Meth. Hospital Registered No. 1125

(e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME MABLE HICKMAN

(a) Residence, No. Corning Mo. St. Corning, Mo.

(Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female

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 Cliff Hickman

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Nov. 1st. 1914

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

25 0 0

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Housewife

9. Industry or business in which work was done, as saw mill, bank, etc.

10. Date deceased last worked at this occupation (month and year)

11. Total time (years) spent in this occupation

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Corning, Mo.

13. NAME John Hollander

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Unknown, Germany

15. MAIDEN NAME Lydia Naber

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Corning, Mo.

17. INFORMANT (ADDRESS) Mr. Cliff Hickman Corning, Mo.

18. BURIAL, CREMATION, OR REMOVAL PLACE DATE Corning, Mo. Nov. 1st. 1939

19. FUNERAL DIRECTOR (NAME) (ADDRESS) FLEEMAN & SON INC. 1946 Cainoun St. Joseph, Mo.

20. FILED Nov. 3. 1939 A. J. Nestle Local Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Nov. 1st. 1939

22. I HEREBY CERTIFY, That I attended deceased from Oct 31st 1939, to Nov. 1st 1939

I first saw her alive on Nov. 1st 1939. Death is said to have occurred on the date stated above, at 5.05 P.M.

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

Date of onset

Other contributory causes of importance:

Name of operation Date of

What test confirmed diagnosis Clinical Was there an autopsy? No

23. If death was due to external causes (violence), fill in also the following:
Accident, suicide, or homicide? Date of injury: 1939
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? No
If so, specify
(Signed) Kirk Bldg. St. Joseph Mo.
(Address)

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

50M-1-12-38 I X14028

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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STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,

....., or by

Registered Apprentice No., working under my personal supervision.

Signed C. A. Swann

Licensed Embalmer No. 4682

P. O. Address St. Joseph, Mo.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, above space should be left blank.

FILL IN ANSWERS TO ALL SPACES
CHECKED IN RED PENCIL.

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1. PLACE OF DEATH
 (a) County Buchanan Registration District No. 85
 (b) Township St Joseph Primary Registration District No. 1001 Registered No. 1125
 (c) City St Joseph (d) Street No. _____ St.
 (If death occurred in Hospital or Institution, write its name instead of street and number)
 (e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME Mable Hickman
 (a) Residence, No. _____ St. (If nonresident, give city or town and State)
 (Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

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

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.
	<u>25</u>	<u>0</u>	<u>0</u>	

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. _____

9. Industry or business in which work was done, as saw mill, bank, etc. _____

10. Date deceased last worked at this occupation (month and year) _____

11. Total time (years) spent in this occupation _____

12. BIRTHPLACE (CITY OR TOWN) _____ (STATE OR COUNTRY) _____

FATHER
 13. NAME _____
 14. BIRTHPLACE (CITY OR TOWN) _____ (STATE OR COUNTRY) _____

MOTHER
 15. MAIDEN NAME _____
 16. BIRTHPLACE (CITY OR TOWN) _____ (STATE OR COUNTRY) _____

17. INFORMANT (ADDRESS) _____

18. BURIAL, CREMATION, OR REMOVAL
 PLACE _____ DATE _____ 19

19. FUNERAL DIRECTOR (ADDRESS) _____

20. FILED Nov. 3 1939 A. Hickman Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Nov 1 1939

22. I HEREBY CERTIFY, That I attended deceased from 19____ to _____, 19____

I last saw h. _____ alive on _____, 19____. Death is said to have occurred on the date stated above, at _____ m.

The principal cause of death and related causes of importance were as follows:
Registered uterus
Endometritis
Attempted delivery by forceps
Puerperal.

Other contributory causes of importance: 149 b

Name of operation _____ Date of _____

What test confirmed diagnosis? _____ Was there an autopsy? _____

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) Overton D. Craig, M. D.
 (Address) St Joseph Mo

SUPPLEMENT

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION should be reported. REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAW.

