

WRITE PEARLINE, WITH OUTFADING 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.

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

19783
Do not use this space.

JUN 15 1940

1. PLACE OF DEATH *W*

(a) County *Drew* Registration District No. *863*

(b) Township *Diney* Primary Registration District No. *6137* Registered No. *19*

(c) City _____ (d) Street No. _____ (If death occurred in Hospital or Institution, write its name instead of street and number) St. _____

(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 *200 Joseph Frank Sicks*

(a) Residence, No. *Houston, Mo., Rural* (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

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

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF *Anna Sicks*

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) *June 22 1865*

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min. *74 10 8 18*

OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. *Farmer*

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 _____

FATHER 12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *Statestown Missouri*

13. NAME *Unknown*

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *Unknown*

MOTHER 15. MAIDEN NAME *Unknown*

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *Unknown*

17. INFORMANT (ADDRESS) *Bert Sicks Houston, Mo.*

18. BURIAL, CREMATION, OR REMOVAL PLACE *Catholic Church* DATE *5/13*

19. FUNERAL DIRECTOR (NAME) (ADDRESS) *S. J. Elijot Houston, Mo.*

20. FILED *5-11-40* 19 *Mabel Shacklett* Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) *May 10 1940*

22. I HEREBY CERTIFY, That I attended deceased from *Dr. Physic in attendance*

I last saw him _____ alive on _____ 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: *Heart and stroke*

Date of onset _____

Other contributory causes of importance: *Supposed Heart attack*

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) *J. H. Harnack* M. D.

(Address) *Houston, Mo.*

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.

RECEIVED

District Health Officer No. **5**,

District File Number **648 671**

Date Filed **6/24/0**

Signed Frank E. Wood

Licensed Embalmer No. **4026**

P. O. Address Houston, 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.