DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED JUL 15 1940

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 21168

Registration District No. 59 | Primary Registration District No. 5094 | Registrar's No. 15

1. PLACE OF DEATH:
(a) County Benton Mo
(b) ~~City or town~~ Cole Camp Mo RFD
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 2 (Specify whether
In this community 256
years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County Jackson
(c) City or town Kansas City Mo
(If outside city or town limits, write "RURAL")
(d) Street No. 0
(If rural, give location)
(e) If foreign born, how long in U. S. A.? years.

3. (a) PRINT FULL NAME FRED G TICKNER
3. (b) If veteran, name war
3. (c) Social Security No.
4. Sex M
5. Color or race W
6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife
6. (c) Age of husband or wife if alive years
7. Birth date of deceased March (Month) 8 (Day) 1880 (Year)

8. AGE:	Years	Months	Days	If less than one day
	60	2	22	hr. min.

9. Birthplace (City, town, or county) (State or foreign country) ✓
10. Usual occupation School Employee
11. Industry or business School
FATHER
12. Name Cornelius Tickner
13. Birthplace Gerard (City, town, or county) Kansas (State or foreign country)
MOTHER
14. Maiden name Emma Moorley
15. Birthplace (City, town, or county) Unknown (State or foreign country)
16. (a) Informant's own signature J Leon Tickner
(b) Address 2830 Chelsea Kansas City Mo
17. (a) Removal (Burial, cremation, or removal) (b) Date thereof 5-31-1940 (Month) (Day) (Year)
(c) Place: burial or cremation
18. (a) Signature of funeral director E L Eackhoff
(b) Address Cole Camp Mo
19. (a) 6-1-40 (Date received local registrar) (b) Sue Selover (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 31 CX year 1940 hour 2:15 minute P M.
21. I hereby certify that I attended the deceased from never never, 19 to Stranger, 19 ; that I last saw him alive on never, 19 ; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Chronic Endocarditis	
Due to	
Due to 92 W	
Other conditions ✓ (Include pregnancy within 3 months of death)	
Major findings: Of operations ✓	
Of autopsy None	

PHYSICIAN
Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify)
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? 63 (Specify type of place)
While at work? (e) Means of injury
23. Signature P S Reser Coroner (M. D. or other) M D
Address Cole Camp Mo Date signed 5-31-40

(Licensed Embalmer's Statement on Reverse Side)

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.

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 E L Eickhoff

Licensed Embalmer No. 730

P. O. Address Ole Camp Mo

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

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

o. 2B
-21-40
X22659

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 21168

Registration District No. 9 Primary Registration District No. 3094 Registrar's No.

1. PLACE OF DEATH:
(a) County Benton
(b) City or town Williams
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution (Specify whether years, months or days)
In this community

2. USUAL RESIDENCE OF DECEASED:
(a) State (b) County
(c) City or town
(If outside city or town limits write "RURAL")
(d) Street No. (If rural, give location)
(e) If foreign born, how long in U. S. A.? years.

3. (a) PRINT FULL NAME Fred A. Tickner
3. (b) If veteran, name war
3. (c) Social Security No.
4. Sex M
5. Color or race W
6. (a) Single, widowed, married, divorced M
6. (b) Name of husband or wife
6. (c) Age of husband, or wife, if alive years
7. Birth date of deceased Mch 8. 1882
(Month) (Day) (Year)
8. AGE: Years 60 Months 2 Days 23 If less than one day hr. min.
9. Birthplace Girard Kas.
(City, town, or county) (State or foreign country)
10. Usual occupation
11. Industry or business
FATHER 12. Name
13. Birthplace (City, town, or county) (State or foreign country)
MOTHER 14. Maiden name
15. Birthplace (City, town, or county) (State or foreign country)
16. (a) Informant
(b) Address
17. (a) (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)
(c) Place: burial or cremation
18. (a) Signature of funeral director
(b) Address
19. (a) 6-1-40 (Date received local registrar) (b) Sue Selover (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 31 year 1940 hour minute M.
21. I hereby certify that I attended the deceased from , 19 , to , 19 ; that I last saw him alive on , 19 ; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death	
Due to	
Due to	
Other conditions (Include pregnancy within 3 months of death)	
Major findings: Of operations	
Of autopsy	

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify)
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place?
While at work? (Specify type of place) (e) Means of injury
23. Signature T. S. Reser (M. D. or other)
Address Cole Camp Mo Date signed

SUPPLEMENTARY