

Registration District No. 24

Primary Registration District No. 4070

Registrar's No. 25

1. PLACE OF DEATH:  
(a) County Cape Girardeau  
(b) City or town Jackson Mo  
(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 \_\_\_\_\_)  
In this community \_\_\_\_\_  
years, months or days

8. (a) PRINT FULL NAME MISSOURI GERTRUDE HICKS  
8. (b) If veteran, name war \_\_\_\_\_ 8. (c) Social Security No. None

4. Sex F 5. Color or race W 6. (a) Single, widowed, married, divorced Single  
6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_ years  
7. Birth date of deceased March 14 1855  
(Month) (Day) (Year)

8. AGE: Years 85 Months 3 Days 7 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

9. Birthplace Cape Girardeau County, Mo  
(City, town, or county) (State or foreign country)

10. Usual occupation House - work

11. Industry or business \_\_\_\_\_  
MOTHER FATHER { 12. Name John Hicks  
13. Birthplace Virginia  
(City, town, or county) (State or foreign country)  
14. Maiden name Magdalena Lee  
15. Birthplace Virginia  
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature M. Black  
(b) Address Jackson Mo

17. (a) Burial (b) Date thereof 6/22/40  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Russell Cemetery

18. (a) Signature of funeral director M. Conroy  
(b) Address Jackson Mo

19. (a) 6-22-40 (b) D. G. Schubert  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:  
(a) State Missouri (b) County Cape Girardeau  
(c) City or town Jackson, Mo.  
(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.

MEDICAL CERTIFICATION  
20. DATE OF DEATH: Month June day 21  
year 1940 hour 8 AM minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from July, 1924, to June 21, 1940  
that I last saw him alive on Aug 20, 1940  
and that death occurred on the date and hour stated above.

Immediate cause of death Myo-Carditis Duration 3 mo  
Due to \_\_\_\_\_  
Due to \_\_\_\_\_

Other conditions Inflammatory Rheumatoid Arthritis  
(Include pregnancy within 8 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? \_\_\_\_\_

(e) Means of injury \_\_\_\_\_  
While at work? \_\_\_\_\_

23. Signature [Signature] (M. D. or other) [Signature]  
Address Jackson Mo Date signed 6-22-40

WHILE I LIVE I WANT TO USE UNFADING BLACK INK—MAKE 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.

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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.....

Licensed Embalmer No.....

P. O. Address.....

**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.**