V. S. No. 2
M—11-10-39
ev. 5-17-39
I X21492

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

11
5
7

FILED SEP 16 1940

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 28006

Registration District No. 85 Primary Registration District No. 1001 Registrar's No. 910

1. PLACE OF DEATH:

(a) County Buchanan

(b) City or town St. Joseph, (If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: 2515 Jones, St., (If not in hospital or institution, write street number or location) 9

(d) Length of stay: In hospital or institution (Specify whether years, months or days) In this community About 40 or 50 yrs.

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Buchanan

(c) City or town St. Joseph (If outside city or town limits write "RURAL")

(d) Street No. 2515 Jones Street (If rural, give location)

(e) If foreign born, how long in U. S. A.? ..... years.

3. (a) PRINT FULL NAME Newton William Hicklin 245

3. (b) If veteran, name war —

3. (c) Social Security No. None

4. Sex Male.

5. Color or race Negro

6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Nora Hicklin

6. (c) Age of husband or wife if alive 65 years

7. Birth date of deceased 1 (Month) 17 (Day) 1865 (Year)

8. AGE: Years 75 Months 7 Days 1 If less than one day ..... hr. ..... min.

9. Birthplace Lexington, (City, town, or county) Missouri (State or foreign country) 0

10. Usual occupation Plaster- Contractor

11. Industry or business Retired

FATHER
12. Name Unknown 9
13. Birthplace Unknown (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name Unknown 9
15. Birthplace Unknown (City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Nora Hicklin

(b) Address 2515 Jones, St.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 8-21-'40 (Month) (Day) (Year)

(c) Place: burial or cremation Ashland Cemetery

18. (a) Signature of funeral director Graves Funeral Home

(b) Address 806 S. 17th, St.

19. (a) Aug 21 1940 (Date received local registrar) (b) [signature] (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month August day 18th year 1940 hour 7 minute 45 P M.

21. I hereby certify that I attended the deceased from Aug 16, 1940, to Aug 18, 1940; that I last saw him alive on Aug 18, 1940 and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Carcinoma of Tr. Colon	?
Due to: Primary - 46	
Due to:	
Other conditions: Met Carcinoma of liver June 40 (Include pregnancy within 3 months of death)	
Major findings: Of operations: No	
Of autopsy: No	

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? 85 (Specify type of place)

While at work (e) Means of injury

23. Signature [signature] (M. D. or other)

Address Kenfalmer Bldg Date signed 8/21/40

(Licensed Embalmer's Statement on Reverse Side)

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 Me

, Registered Apprentice No. [redacted]

working under my personal supervision.

Signed A. F. Moore

Licensed Embalmer No. 948

P. O. Address St. Joseph.

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.