

Registration District No. 237

SEP 19 1940

Registration District No. 5823

Registrar's No.

1. PLACE OF DEATH:

(a) County Dade, Wash. District TWENTY
 (b) City or town Greenfield, Mo. Rt. 1.
 (c) Name of hospital or institution: _____
 (If outside city or town limits, write "RURAL" and name of township)

(d) Length of stay: In hospital or institution _____ (Specify whether
 In this community Many years. (Specify whether
 years, months or days)

3. (a) PRINT FULL NAME Redman Josh. Hickey, 700

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Married6. (b) Name of husband or wife Wife 6. (c) Age of husband or wife if alive 72 1/2 years
Nora May Hickey7. Birth date of deceased October, 19, 1865
(Month) (Day) (Year)8. AGE: Years 74 Months 9 Days 27 If less than one day
hr. _____ min.9. Birthplace Carthage, Mo. (City, town, or county) (State or foreign country)10. Usual occupation Farmer

11. Industry or business _____

12. Name Redman Josh. Hickey.13. Birthplace Missouri (City, town, or county) (State or foreign country)14. Maiden name Nancy Byrd. (City, town, or county) (State or foreign country)15. Birthplace Missouri. (City, town, or county) (State or foreign country)16. (a) Informant's own signature Ralph Hickey(b) Address Greenfield Mo17. (a) Burial (b) Date thereof Aug. 19, 40
(Burial, cremation, or removal) (Month) (Day) (Year)(c) Place: burial or cremation Pierce City Cem.18. (a) Signature of funeral director J. W. Ward(b) Address Greenfield, Mo19. (a) Sept. 12-1940 (b) Geo. W. Wenz
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State 0 Missouri (b) County Dade(c) City or town Greenfield, MO, Rt. 1.
(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 Aug. day 18,
year 1940. hour 12 minute 10 .A. M.21. I hereby certify that I attended the deceased from
May, 1935, to Aug 18, 1940
that I last saw him alive on aug 17, 1940
and that death occurred on the date and hour stated above.Immediate cause of death Arthritis - Chronic - 15 yrs
deformities Duration _____

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 sta-
tistically

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? _____

214 (Specify type of place)
While at work? _____ (e) Means of injury _____23. Signature J. J. Drisdell (M. D. or other) MDAddress Greenfield, MO Date signed 8/19/40

RECEIVED

District Health Officer No. 6;

District File Number 940-2661

Date Filed SEP 17 1940

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 J. W. Ward

Licensed Embalmer No. 2832

P. O. Address Greenfield N.H.

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.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **283 71**

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

Registration District No. **237**

Primary Registration District No. **5829**

Registrar's No. _____

1. PLACE OF DEATH

(a) County **Dade**
(b) City or town **Wash. D.C.**
(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
In this community _____
years, months or days)

3. (a) PRINT FULL NAME **Redman Jack Hickey**

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 **(Oct 19 1865)**
(Month) (Day) (Year)

8. AGE: Years **74** Months **7** Days **29** If less than one day _____ min.

9. Birthplace _____ (City, town, or county) (State, foreign country)

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER { 12. Name _____

13. Birthplace _____ (City, town, or county) (State or foreign country)

14. Maiden name _____

15. Birthplace _____ (City, town, or county) (State or foreign country)

16. (a) Informant _____

(b) Address _____

17. (a) _____ (b) Date thereof _____
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) **Oct 5-40** (b) **Les R. Neer**
(Date received local registrar) (Registrar's signature)

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.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Aug** day **18**
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.

Immediate cause of death _____

Due to _____

Due to _____

Other conditions _____
(Include pregnancy within 3 months of death)

Major findings:
Of operations _____

Of autopsy _____

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?

(Specify type of place)
While at work? _____ (e) Means of injury _____

23. Signature _____ (M. D. or other) _____

Address _____ Date signed _____

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

SUPPLEMENTAL

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

