

No. 2
11-10-39
5-17-39
I X21492

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH
1003

State File No. 34101
8798
Registrar's No.

Registration District No. 791

Primary Registration District No.

1. PLACE OF DEATH:

(a) County _____
(b) City or town Athens
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Missouri Pacific Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 1 WK
(Specify whether _____)
In this community 1 WK
years, months or days

8. (a) PRINT FULL NAME FLODA-VELLA NICKS

8. (b) If veteran, name war No
3. (c) Social Security No. None

4. Sex Female 5. Color or race white
6. (a) Single, widowed, married, divorced married
6. (b) Name of husband or wife Morton Hicks
6. (c) Age of husband or wife if alive 52 years
7. Birth date of deceased (Month) 9 (Day) 13 (Year) 1890

8. AGE: Years 50 Months 1 Days 11
If less than one day hr. _____ min. _____

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

10. Usual occupation Housewife

11. Industry or business _____

12. Name J W Moore

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

14. Maiden name Unknown

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

16. (a) Informant Morton Hicks

(b) Address Dupo Ill

17. (a) Removal (b) Date thereof 10-26-40
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Fresno Calif

18. (a) Signature of funeral director J G Schneider

(b) Address Columbia Ill

19. (a) OCT 25 1940 (b) _____
(Date received local registrar) (Signature of registrar)

2. USUAL RESIDENCE OF DECEASED:

(a) State Illinois (b) County _____
(c) City or town Dupo (If outside city or town limits write "RURAL") NR
(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 OCT day 24
year 1940 hour 6 minute 15 A. M.

21. I hereby certify that I attended the deceased from Oct. 19
_____ 1940 to Oct. 24 1940
that I last saw her alive on Oct. 24 1940
and that death occurred on the date and hour stated above.

Immediate cause of death _____

Due to Carcinoma of rectum

Due to _____

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

Major findings: Of operations Carcinoma rectum

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? _____

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

23. Signature W H Russell (M. D. or other) _____

Address 300 Sac. Hospital Date signed 10-24-40

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

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

John Hatten

Licensed Embalmer No. 3880

P. O. Address.....

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

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