DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 36064

NOV 20 1940

Registration District No. 689 Primary Registration District No. 5917 Registrar's No.

1. PLACE OF DEATH:
(a) County: Pike
(b) City or town: Rural - Buffalo (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: Not in Hospital (Specify whether)
In this community: 6 hours (years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State: Mo (b) County: Pike
(c) City or town: Rural - Buffalo (If outside city or town limits, write "RURAL")
(d) Street No.: R.F.D. Bowling Green, Mo. (If rural, give location)
(e) If foreign born, how long in U. S. A.? ____ years.

3. (a) PRINT FULL NAME: Infant - Not named
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: Single
6. (b) Name of husband or wife: —
6. (c) Age of husband or wife if alive: ____ years
7. Birth date of deceased: Oct. (Month) 20 (Day) - 1940 (Year)

8. AGE: Years — Months — Days — If less than one day: 6 hr. — min.

9. Birthplace: Pike Co - Buffalo Township (City, town, or county) (State or foreign country)
10. Usual occupation: 0
11. Industry or business: 0

FATHER
12. Name: Edd Hickerson
13. Birthplace: Pike Co Mo (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name: Ruth Dixon
15. Birthplace: Pike Co Mo (City, town, or county) (State or foreign country)

16. (a) Informant's own signature: Edd Hickerson
(b) Address: Bowling Green Mo
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof: Oct. 20-1940 (Month) (Day) (Year)
(c) Place: burial ~~or cremation~~: Mount Air Cemetery
18. (a) Signature of funeral director: W. B. E. Moore
(b) Address: Bowling Green Mo
19. (a) 10/20/40 (Date received local registrar) (b) B. E. Haley (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 10 day 20 year 1940 hour 8 minute 9 A.M.

21. I hereby certify that I attended the deceased from 10/20/40, 19__, to 10/20/40, 19__; that I last saw him alive on 10/20/40, 19__; and that death occurred on the date and hour stated above.

Immediate cause of death:	Duration
Cardiac Insufficiency	6 hrs
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? (Specify type of place)
While at work? (e) Means of injury:

23. Signature: T. M. Walters (M. D. or other) MD
Address: Bowling Green Mo Date signed 10/21/40

(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.

RECEIVED
District Health Officer No. 10
District File Number 11-40-2070
Date Filed NOV 8 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 None, Registered Apprentice No. ..... working under my personal supervision.

Signed None

Licensed Embalmer No. .....

P. O. Address .....

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.