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DEC 12 1940

Registration District No. 471

Primary Registration District No. 4284

Registrar's No. 37

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

1. PLACE OF DEATH

(a) County Lawrence
(b) City or town Pierce City, Mo.
(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 2
(Specify whether
In this community ✓
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County Lawrence
(c) City or town Pierce City, Mo.
(If outside city or town limits, write "RURAL")
(d) Street No. 0
(If rural, give location)
(e) If foreign born, how long in U. S. A? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov. day 17
year 1940 hour 6 minute P M.
21. I hereby certify that I attended the deceased from Sept. 10
1940, 19____, to Nov. 17, 1940
that I last saw her alive on Nov. 13, 1940
and that death occurred on the date and hour stated above.

Immediate cause of death Chronic Myocarditis
Due to Sclerosis of Coronary arteries

Other conditions
(Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy

Duration
4 1/2 yrs.
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?

423
While at work? (Specify type of place)
(e) Means of injury
23. Signature G B W [unclear] (M. D. or other)
Address Pierce City, Mo. Date signed 11/19/40

3. (a) PRINT FULL NAME Quendia Elizabeth Hicks

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

4. Sex Female 5. Color or race N. 6. (a) Single, widowed, married, divorced Widowed

6. (b) Name of husband or wife William (c) Age of husband or wife if alive _____ years

7. Birth date of deceased (Month) Oct (Day) 28 (Year) 1910

8. AGE:	Years	Months	Days	If less than one day
	<u>84</u>	<u>18</u>		hr. _____ min.

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

10. Usual occupation ky

11. Industry or business

12. Name Jessie Howell

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

14. Maiden name Jessie Mansfield

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

16. (a) Informant Jessie Hicks

(b) Address Pierce City, Mo

17. (a) (Burial, cremation, or removal) (b) Date thereof Nov 19 1940
(Month) (Day) (Year)

(c) Place: burial or cremation City cemetery

18. (a) Signature of funeral director Wm [unclear]

(b) Address Pierce City, Mo
19. (a) Nov 15 1940 (b) G B W [unclear]
(Date received local registrar) (Registrar's signature)

RECEIVED

District Health Officer No. 6,

District File Number ~~1240-3157~~

Date Filed DEC 12 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 me

....., Registered Apprentice No.

working under my personal supervision.

Signed

John Armes

Licensed Embalmer No. 1812

P. O. Address Peace City, Mo

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, fact should be so stated above.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 39057

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

Registration District No. 471

Primary Registration District No. 4284

Registrar's No. _____

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

1. PLACE OF DEATH:

(a) County Lawrence

(b) City or town Piassa city
(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 Amanda Elizabeth Hilker

3. (a) PRINT FULL NAME Amendia Elizabeth Hicks

(b) If veteran, name war _____

(c) Social Security No. _____

4. Sex F 5. Color or race W

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

6. (b) Name of husband or wife _____

6. (c) Age of husband, or wife, if alive _____ year

7. Birth date of deceased _____
(Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
<u>84</u>		<u>18</u>	hr. min.

9. Birthplace Near Bowling Green, Ky.
(City, town, or county) (State or foreign country)

10. Usual occupation _____

11. Industry or business _____

MOTHER { 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) Jan 19 (b) E. B. Wright
(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 11 day 17
year 1940 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____; that I last saw h. _____ 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 _____

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? _____

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

23. Signature E. B. Wright (M. D. or other) _____
Address Piassa, Mo.

SUPPLEMENTAL COPY

S-39057

1940