FILED JAN 20 1941 FILED JAN 20 1941 (SEC)

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 42242

Registration District No. 218 Primary Registration District No. 3015 Registrar's No. 134

1. PLACE OF DEATH:

(a) County Cooper

(b) City or town Boonville Mo
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: Ravensway Clinic
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 1 week (Specify whether
In this community
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Cooper

(c) City or town Rural
(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.

3. (a) PRINT FULL NAME Margaret Louise ~~Griesbach~~ Hickam

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex Female

5. Color or race White

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

6. (b) Name of husband or wife Owen Hickam

6. (c) Age of husband ~~or wife~~ if alive 34 years

7. Birth date of deceased 7 (Month) 14 (Day) 1918 (Year)

8. AGE: Years 22 + Months 5 Days 6 If less than one day hr. min.

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

10. Usual occupation Housewife

11. Industry or business

FATHER
12. Name Frank Griesbach
13. Birthplace Moniteau (City, town, or county) Missouri (State or foreign country)

MOTHER
14. Maiden name Bertha Reichel
15. Birthplace Moniteau Co (City, town, or county) Missouri (State or foreign country)

16. (a) Informant's own signature Bertha Griesbach
(b) Address Prairie Home Mo

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 12 (Month) 22 (Day) 1940 (Year)
(c) Place: burial or cremation Moniteau Co Cem.

18. (a) Signature of funeral director C. Albert Hornbeck
(b) Address Prairie Home Mo

19. (a) 12-21-40 (Date received local registrar) (b) D. Cooper (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec day 20 year 1940 hour 6 minute P M.

21. I hereby certify that I attended the deceased from Dec 1, 1940 to Dec 20, 1940 that I last saw her alive on Dec 18, 1940 and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Acute nephritis	3 wk
Due to: Syphilis	
Pregnancy	
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 A L Wunderlich (M. D. or other) Mrs
Address Prairie & Forsyth Mo Date signed 12-22-40

(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.

34

MAY 16 1947

RECEIVED
District Health Officer No. 8,
District File Number 1-8-41
Date Filed

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 C. Albert Hornbeck

Licensed Embalmer No. 2714

P. O. Address Prairie Home, M

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

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

No. 2B
2-21-40
I X22659

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 42242

Registration District No. 218 Primary Registration District No. 3015 Registrar's No.

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

SUPPLEMENTARY

1. PLACE OF DEATH:

(a) County Cooper

(b) City or town Boonville
(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)

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.

3. (a) PRINT FULL NAME Margaret Louise Hickam

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex F

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 (Month) (Day) (Year)

8. AGE: Years 22 Months 5 Days 6 If less than one day hr. min.

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

10. Usual occupation

11. Industry or business

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

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

16. (a) Informant
(b) Address

17. (a) (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)
(c) Place: burial or cremation

18. (a) Signature of funeral director
(b) Address

19. (a) (Date received local registrar) (b) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec day 20
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 Acute Nephritis
Syphilis & Pregnancy
Due to abortion
Due to N.M.D.

Other conditions
(Include pregnancy within 3 months of death)

Major findings:
Of operations 140
Of autopsy

Duration

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 A L Meredith M.D. or other
Address Prairie Home Mo Date signed 3/14/41

MAY 16 1947

1940
S-42242