

No. 2  
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DEPARTMENT OF COMMERCE

BUREAU OF THE CENSUS

FILED FEB 14 1941

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. 2622

Registration District No. 318

Primary Registration District No. 2001

Registrar's No. 69

1. PLACE OF DEATH:

(a) County GREENE

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

(c) Name of hospital or institution Springfield Baptist Hospital  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution week  
(Specify whether)

In this community 5 years  
years, months or days)

3. (a) PRINT FULL NAME WALTER M. HICKMAN

3. (b) If veteran, name war SS 500-09-5111

3. (c) Social Security No. None

4. Sex Male

5. Color or race White

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

6. (b) Name of husband or wife Ornah Degeard Hickman

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

7. Birth date of deceased August 26 1885  
(Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
<u>55</u>	<u>4</u>	<u>27</u>	hr. min.

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

10. Usual occupation Carpenter

11. Industry or business None

12. Name W. M. Hickman

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

14. Maiden name Adeline Perry

15. Birthplace Not known Unknown  
(City, town, or county) (State or foreign country)

16. (a) Informant Wilma Hickman

(b) Address Springfield, Mo.

17. (a) Normal (b) Date thereof January 25 1941  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Maple Park

18. (a) Signature of funeral director J. C. Blum

(b) Address Springfield, Mo.

19. (a) 1-25-41 (b) W. E. Handley md  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Greene 39

(c) City or town Springfield 3  
(If outside city or town limits, write "RURAL.") 6

(d) Street No. Winwood Apts.  
(If rural, give location) 0

(e) If foreign born, how long in U. S. A. ? \_\_\_\_\_ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month January day 23rd  
year 1941 hour 10 minute 30 A.M.

21. I hereby certify that I attended the deceased from Nov 12, 1940, to Jan 23, 1941;  
that I last saw him alive on Jan 23, 1941;  
and that death occurred on the date and hour stated above.

Immediate cause of death

Leukemia chronic lymphatic 2 yrs

Due to Exhaustion 1 mo

Due to Anemia secondary 2 yrs

Other conditions (Include pregnancy within 3 months of death)

Major findings: 94%

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? 9th  
(Specify type of place) \_\_\_\_\_

While at work (e) Means of injury \_\_\_\_\_

23. Signature Robert Glynn (M. D. or other) MD  
Address Springfield Date signed 1-25-41

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. <sup>285</sup>.....  
working under my personal supervision.

Signed Ph. Luciani

Licensed Embalmer No. 3687

P. O. Address Springfield, 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.**