

No. 2
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FEB 17 1941

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

3171
State File No. _____
Registrar's No. 4

Registration-District No. 467

Primary Registration District No. 4280

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

1. PLACE OF DEATH:
(a) County Lawrence
(b) City or town Aurora
(c) Name of hospital or institution:
702 McNatt Ave
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____
(Specify whether _____)
In this community Life
years, months or days _____

3. (a) PRINT FULL NAME Grant Rickman
(b) If veteran, name war _____
(c) Social Security No. _____

4. Sex Male 5. Color or race White
6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife Ollie Rickman
6. (c) Age of husband or wife if alive 58 years
7. Birth date of deceased Dec. 1 1866
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
74 1 14 hr. min.

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

10. Usual occupation Retired Farmer

11. Industry or business _____

MOTHER FATHER
12. Name N.W. Richardson
13. Birthplace Lawrence County Missouri
(City, town, or county) (State or foreign country)
14. Maiden name Elizabeth Pace
15. Birthplace Lawrence County Missouri
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs Ollie Rickman
(b) Address Aurora Mo.

17. (a) Burial (b) Date thereof 1/16/41
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Aurora Mo.

18. (a) Signature of funeral director J. H. King 4114
(b) Address Aurora Mo.

19. (a) 2-3-41 (b) J. D. Clendenen MD
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED: 55
(a) State Missouri (b) County Lawrence
(c) City or town Aurora
(If outside city or town limits, write "RURAL")
(d) Street No. 702 McNatt Ave.
(If rural, give location)
(e) If foreign born, how long in U. S. A.? 0 years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan. day 14
year 1941 hour 9 minute 15A. M.

21. I hereby certify that I attended the deceased from Jan 14, 1941, to Jan 14, 1941,
that I last saw him alive on Jan 13-41, 1941,
and that death occurred on the date and hour stated above.

Immediate cause of death
Cancer involving face & throat
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 J. H. King 4114 (M. D. or other) D
Address 212 W. Pleasant Aurora Mo. Date signed 1/14/41

5
RECEIVED

District Health Officer No. 6,

District File Number 141-194

Date Filed FEB 4 1929

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 *Herman Curridge*

Licensed Embalmer No. 3072

P. O. Address Aurora 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.

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STANDARD CERTIFICATE OF DEATH

State File No. 3171

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

Registration District No. 467

Primary Registration District No. 4280

Registrar's No.

1. PLACE OF DEATH:

(a) County Lawrence
(b) City or town Aurora
(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)

3. (a) PRINT FULL NAME Grant Rickman

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

4. Sex M 5. Color of 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 _____ year

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

8. AGE: Years 74 Months 1 Days 14 If less than one day _____ min.

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

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER { 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 _____ (Month) (Day) (Year)

(Burial, cremation, or removal)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) _____ (b) _____ (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.

19. MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan day 14
year _____ 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 Cancer involving the face & throat
Due to Primary lesion on lip
Due to _____

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

Major findings: _____
Of operations _____

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 _____ (M. D. or other)

Address _____ Date signed _____

SUPPLEMENTARY

Duration
PHYSICIAN
Underline the cause to which death should be charged statistically.

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

