DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

APR 7 1941

Registration District No. 957

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 10558

Primary Registration District No. 5392

Registrar's No. 30

1. PLACE OF DEATH:

(a) County: Douglas

(b) City or town: Drury Jackson
(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 years, months or days)
In this community

2. USUAL RESIDENCE OF DECEASED:

(a) State: Missouri (b) County: Douglas

(c) City or town: Drury
(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.? 0 years.

3. (a) PRINT FULL NAME: Robert T. Hicks

3. (b) If veteran, name war:

3. (c) Social Security No.: None

4. Sex: Male

5. Color or race: White

6. (a) Single, widowed, married, divorced: Divorced

6. (b) Name of husband or wife: ~~Lulu Hicks Dive~~

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

7. Birth date of deceased: Dec. (Month) 8 (Day) 1884 (Year)

8. AGE: Years	Months	Days	If less than one day
56	3	10	hr. min.

9. Birthplace: Douglas Co. (City, town, or county) Mo. (State or foreign country)

10. Usual occupation: Merchant and farmer

11. Industry or business:

MOTHER FATHER

12. Name: James P. Hicks

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

14. Maiden name: Jonain Riley

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

16. (a) Informant: Murl Hicks

(b) Address: Drury, Mo.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof: 3-20-41 (Month) (Day) (Year)

(c) Place: burial or cremation: Henderson

18. (a) Signature of funeral director: Clinkingbeard Funeral Home

(b) Address: Ava, Missouri

19. (a) 3-20-1941 (Date received local registrar) (b) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 18 year 1941 hour 11 minute P M.

21. I hereby certify that I attended the deceased from Mar 18-41 only, 1941, 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	Duration
Lobar Pneumonia	
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: J. L. Gentry (M. D. or other) 0

Address: Ava Mo. Date signed 3-18-41

(Licensed Embalmer's Statement on Reverse Side)

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

RECEIVED
District Health Officer No. 6,
District File Number 441-508
Date Filed APR 2 1941

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 W B Hutchinson

Licensed Embalmer No. 3431

P. O. Address.....

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

If this body is not embalmed, fact should be so stated above.

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 10538

Registration District No. 957 Primary Registration District No. 5393 Registrar's No. 30

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

1. PLACE OF DEATH:
(a) County: Douglas
(b) City or town: Jackson T P
(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 years, months or days)
In this community .....

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) Citizen of foreign country? ..... (Yes or No)
If yes, name country .....

3. (a) PRINT FULL NAME: Robert T. Hicks
3. (b) If veteran, name war .....
3. (c) Social Security No. .....

4. Sex: M
5. Color or race: W
6. (a) Single, widowed, married, divorced: Div
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	Months	Days	If less than one day
56	3	10	..... hr. ..... min.

9. Birthplace ..... (City, town, or county) ..... (State or foreign country)
10. Usual occupation .....
11. Industry or business .....
FATHER 12. Name .....
FATHER 13. Birthplace ..... (City, town, or county) ..... (State or foreign country)
MOTHER 14. Maiden name .....
MOTHER 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) 3-20 1941 (Date received local registrar) (b) Gebre King White (Registrar's signature)

SUPPLEMENTARY

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Mar day 18 year 1941 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 ..... *Duration*
Due to .....
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 J. L. Gentry (M. D. or other)
Address Cara Mo. Date signed .....

(Licensed Embalmer's Statement on Reverse Side)

S-10558-1941

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.....

Licensed Embalmer No.....

P. O. Address.....

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

If this body is not embalmed, fact should be so stated above.