FILED APR 15 1941

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 14054

Registration District No. 461 Primary Registration District No. 3024 Registrar's No.

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

1. PLACE OF DEATH:
(a) County: Lafayette
(b) City or town: Lexington
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: N. 16th St.
(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: Life 1

2. USUAL RESIDENCE OF DECEASED:
(a) State: Mo. (b) County: Lafayette
(c) City or town: Lexington
(If outside city or town limits, write "RURAL")
(d) Street No.: N. 16th St. 3
(If rural, give location)
(e) If foreign born, how long in U. S. A.? years.

3. (a) PRINT FULL NAME: William Hicks
3. (b) If veteran, name war: —
3. (c) Social Security No.:
4. Sex: Male
5. Color or race: Colored
6. (a) Single, widowed, married, divorced: Married
6. (b) Name of husband or wife: Carry Taylor
6. (c) Age of husband or wife if alive: 70 years
7. Birth date of deceased: Nov (Month) 4 (Day) 1862 (Year)

8. AGE: Years 78 77 Months 4 Days 12 If less than one day hr. min.

9. Birthplace: Higginsville (City, town, or county) Mo (State or foreign country)
10. Usual occupation: Coal Miner
11. Industry or business:
MOTHER FATHER
12. Name: Washington Hicks
13. Birthplace: Ky (City, town, or county) (State or foreign country)
14. Maiden name: Sarah Winnie
15. Birthplace: Higginsville (City, town, or county) Mo (State or foreign country)
16. (a) Informant: Mrs Wm Hicks
(b) Address: Lexington, Mo
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof: 3-21-41 (Month) (Day) (Year)
(c) Place: burial or cremation: Lexington, Mo
18. (a) Signature of funeral director: Winkler
(b) Address: Lexington, Mo
19. (a) 3/21/41 (Date received local registrar) (b) Delia Bates (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month: Mar. day: 16 year: 1941 hour: 11 minute: P. M.
21. I hereby certify that I attended the deceased from March 16, 1941, to March 16 1941 that I last saw him alive on March 16, 1941; and that death occurred on the date and hour stated above.

Immediate cause of death: Myocarditis (Chr) — Duration
Due to: Pulmonary Edema — 1 hrs.
Due to: Senility.
Other conditions (Include pregnancy within 3 months of death):
Major findings: Of operation: none
Of autopsy: none

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: [illegible] (M. D. or other)
Address: Lexington, Mo Date signed: 3/19/41

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Officer No. 8,
District File Number
Date Filed 4-10-41

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 Forrest F Kempel

Licensed Embalmer No. 32757

P. O. Address Lexington, 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, fact should be so stated above.

No. 2
-1-4-41
-17-39
X26390

ROWENA MOORE

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 11154

Registration District No. 461 Primary Registration District No. 3024 Registrar's No.

1. PLACE OF DEATH:

(a) County Lafayette

(b) City or town Lexington
(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) Citizen of foreign country? (Yes or No)

If yes, name country

3. (a) PRINT FULL NAME Wm Hicks

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex M

5. Color or race Col

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 Nov (Month) 4 (Day) 1862 (Year)

8. AGE: Years	Months	Days	If less than one day
78. ~~78~~	4	12	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) 3/21/41 (Date received local registrar) (b) Delia Bates (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Mar day 16
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.

	Duration
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?
(Specify type of place)
While at work? (e) Means of injury

23. Signature G. C. West (M. D. or other)
Address Lexington Mo Date signed

SUPPLEMENTARY

(Licensed Embalmer's Statement on Reverse Side)

1941
5-11154

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 wit the above constitutes grounds for revocation of license.)

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