

Registration District No. 231

Primary Registration District No. 5315

Registrar's No.

1. PLACE OF DEATH:

(a) County Crawford  
 (b) City or town Union  
 (c) Name of hospital or institution: 1  
 (If not in hospital or institution, write street number or location)  
 (d) Length of stay: In hospital or institution all his life (Specify whether years, months or days)

3. (a) PRINT FULL NAME Thomas H. Dicus

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

4. Sex M 5. Color or race W 6. (a) Single, widowed, married, divorced divorced  
 6. (b) Name of husband or wife - 6. (c) Age of husband or wife if alive 2 years (Month) (Day) (Year)

7. Birth date of deceased 5 2 1925  
 (Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>16</u>	<u>2</u>	<u>12</u>	hr. min.

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

10. Usual occupation Student

MOTHER FATHER

11. Industry or business  
 12. Name Calvin E. Dicus  
 13. Birthplace Crawford Mo  
 (City, town or county) (State or foreign country)  
 14. Maiden name Etha E. Cassidy  
 15. Birthplace Crawford Mo  
 (City, town or county) (State or foreign country)

16. (a) Informant's own signature Calvin E. Dicus  
 (b) Address Keyaville Mo

17. (a) V (b) Date thereof 7-16-1941  
 (Burial, cremation, or removal) (Month) (Day) (Year)  
 (c) Place: burial or cremation Keyaville Cemetery

18. (a) Signature of funeral director W. J. ...  
 (b) Address St. Louis Mo

19. (a) 7/16/41 (b) ...  
 (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Crawford  
 (c) City or town Rural (Union)  
 (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.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 7 day 14th  
 year 1941 hour 7:11 minute 45P M.  
 21. I hereby certify that I attended the deceased from July 1, 1941, to July 16, 1941, that I last saw him alive on July 14, 1941, and that death occurred on the date and hour stated above.

Immediate cause of death: Acute interstitial nephritis  
 Due to accidental automobile wreck  
 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 7-16-41  
 (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 R. E. Parker (M. D. or other)  
 Address St. Louis Mo Date signed 7-22-41

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

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

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.

JUL 18 1941

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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 *L. J. Jones*

....., Registered Apprentice No. ....

working under my personal supervision.

Signed *L. J. Jones*

Licensed Embalmer No. *2379*

P. O. Address *Steubenville 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, above space should be left blank.**

Registration District No. 231

Primary Registration District No. 5315

Registrar's No. \_\_\_\_\_

1. PLACE OF DEATH:

(a) County Crawford

(b) City or town Union  
(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 \_\_\_\_\_  
years, months or days

3. (a) PRINT FULL NAME Thomas H. Ficus

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 s

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	Months	Days	If less than one day
				hr. 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 \_\_\_\_\_  
(City, town, or county) (State or foreign country)

15. Birthplace \_\_\_\_\_  
(City, town, or county) (State or foreign country)

16. (a) Informant \_\_\_\_\_

(b) Address \_\_\_\_\_

17. (a) Burial (b) Date thereof \_\_\_\_\_  
(Burial, cremation, or removal) (Month) (Day) (Year)

(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) Citizen of foreign country \_\_\_\_\_  
(Yes or No)  
If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 14  
year 1987 hour \_\_\_\_\_ minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_, 19\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_;  
that I last saw him \_\_\_\_\_ alive on \_\_\_\_\_, 19\_\_\_\_;  
and that death occurred on the date and hour stated above.

Immediate cause of death: acute interstitial nephritis Duration \_\_\_\_\_

Due to: accident, automobile wreck, no collision, wet (no high way), by road

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) accident

(b) Date of occurrence \_\_\_\_\_

(c) Where did injury occur: near Rayville MO  
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place?  
on road, near home

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

23. Signature: A. B. Pender (M. D. or other) \_\_\_\_\_

Address: Steelville MO Date signed: 8/15/87

SUPPLEMENTARY

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

Steelville, mo.

