DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED OCT 22 1941

X23159

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

Dr. Chester 32129

State File No. 32129

Registration District No. 614 | Primary Registration District No. 5816 | Registrar's No. 16

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

1. PLACE OF DEATH:

(a) County: NEWTON

(b) City or town: NEOSHO-Rural Stanley Twp.
(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 1 (Specify whether years, months or days)
In this community

2. USUAL RESIDENCE OF DECEASED: 073 0 0

(a) State: MISSOURI (b) County: NEWTON
(c) City or town: RURAL
(If outside city or town limits, write "RURAL")
(d) Street No.: RURAL ROUTE #5 NEOSHO
(If rural, give location)
(e) If foreign born, how long in U. S. A.? 0 years.

3. (a) PRINT FULL NAME: FAYE HICKS

3. (b) If veteran, name war: NONE

3. (c) Social Security No.: NONE

4. Sex: FEMALE | 5. Color or race:

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

6. (b) Name of husband or wife: SINGLE

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

7. Birth date of deceased: October (Month) 5 (Day) 1923 (Year)

8. AGE: Years 17 | Months 8 | Days 11 | If less than one day hr. min.

9. Birthplace: OZARK Co. (City, town, or county) MISSOURI (State or foreign country)

10. Usual occupation: AT HOME

11. Industry or business:

FATHER
12. Name: JASPER HICKS
13. Birthplace: OZARK Co. (City, town, or county) MISSOURI (State or foreign country)

MOTHER
14. Maiden name: DOTTIE FROST
15. Birthplace: (City, town, or country) OKLAHOMA (State or foreign country)

16. (a) Informant: Jasper Hicks
(b) Address: Neosho Mo. R#5

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 6-19-1941 (Month) (Day) (Year)
(c) Place: burial or cremation: Gibson Cemetery

18. (a) Signature of funeral director: Carley Thompson
(b) Address: Neosho Mo.

19. (a) 10-7-41 (Date received local registrar) (b) R. E. Rollins (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 17th year 1941 hour 9:45 minute P. M.

21. I hereby certify that I attended the deceased from March 24, 1941, to May 30, 1941, that I last saw her alive on May 30, 1941, and that death occurred on the date and hour stated above.

Immediate cause of death	Duration
Pulmonary tuberculosis	0 m. 6 Mo.
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: Charles D. Chester (M. D. or other) D.O.
Address: Granby, Mo Date signed 8/29/41

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Officer No. 6,
District File Number 1041-1632
Date Filed OCT 16 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 Carley Thompson

Licensed Embalmer No. 3259

P. O. Address Neosho Mo

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

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

S. No. 2B
—8-21-41
I X29288

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. 32129

Registration District No. 614 Primary Registration District No. 5816 Registrar's No.

1. PLACE OF DEATH:
(a) County: Newton
(b) City or town: Nioshe Rural
(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: Faye Hicks
3. (b) If veteran, name war
3. (c) Social Security No.

4. Sex: F
5. Color or race: White
6. (a) Single, widowed, married, divorced: S
6. (b) Name of husband or wife
6. (c) Age of husband or wife if alive years
7. Birth date of deceased: Oct 5 1923 (Month) (Day) (Year)

8. AGE: Years 17 Months 8 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
12. FATHER Name
13. FATHER Birthplace (City, town, or county) (State or foreign country)
14. MOTHER Maiden name
15. MOTHER 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) 10-7-41 (Date received local registrar) (b) LeRoland M.D. (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June Day 17 year 1941 hour minute M.
21. I hereby certify that I attended the deceased from 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	
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 (M. D. or other)
Address Date signed

SUPPLEMENTARY

32129