

No. 5-4
-17-

FILED NOV 7 1942
Registration District No. **42**

Primary Registration District No. **1000**

Registrar's No. **816**

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

1. PLACE OF DEATH:

(a) County **Buchanan**

(b) City or town **St. Joseph**
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: **St. Joseph Hospital**
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution **3 days**
(Specify whether years, months or days)

In this community **6 years**

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **Buchanan**

(c) City or town **St. Joseph**
(If outside city or town limits, write "RURAL")

(d) Street No. _____
(If rural, give location)

(e) Citizen of foreign country? **No** (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME **George Hickman**

3. (b) If veteran, name war **No**

3. (c) Social Security No. **None**

4. Sex **male** 5. Color or race **white**

6. (a) Single, widowed, married, divorced **single**

6. (b) Name of husband or wife _____

6. (c) Age of husband or wife if alive **28** years

7. Birth date of deceased: **May 28 1874**
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day

68 4 28 hr. min.

9. Birthplace: **Laclede County Missouri**
(City, town, or county) (State or foreign country)

10. Usual occupation **None**

11. Industry or business _____

MOTHER FATHER {

12. Name **Martin Hickman**

13. Birthplace **Unknown Tennessee**
(City, town, or county) (State or foreign country)

14. Maiden name **Mary Ann Tennison**

15. Birthplace **Laclede County Missouri**
(City, town, or county) (State or foreign country)

16. (a) Informant **Mrs. P. A. Davis**

(b) Address **Lebanon, Missouri**

17. (a) **Burial** (b) Date thereof **10 12 1942**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Mt. Auburn Cemetery**

18. (a) Signature of funeral director **Walter Meischopper**

(b) Address **13th. & Faraon St., St. Joseph, Mo.**

19. (a) **10-12-42** (b) **Rose Herzog**
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **October** day **10th.**
year **1942** hour **11** minute **55 P.** M.

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

Immediate cause of death **Bronchial Pneumonia** Duration **3 days**

Due to **Nephritis** **over 3 days**

Due to _____

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

Major findings: Of operations _____

Of autopsy **No 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)

(e) Means of injury _____

23. Signature **Walter Meischopper** (M. D. or other) _____
Address **218 7th** Date signed **10/12/42**

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.....

Geo E Daniel

Licensed Embalmer No. **3300 Missouri**

P. O. Address..... **St. Joseph, Missouri.**

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.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 33229
Registrar's No. 816

Registration District No. 42 Primary Registration District No. 1000

1. PLACE OF DEATH:

(a) County Buchanan
(b) City or town St Joseph
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution St Joe Hosp.
(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

George Hickman

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 5

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

7. Birth date of deceased May 28 (Month) (Day) (Year)

8. AGE: Years 48 Months 4 Days 20 If less than one day _____ min.

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

10. Usual occupation _____

11. Industry or business _____

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) _____ (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)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 10 Day 20 Year 1943 Minute _____ M.

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

Immediate cause of death bronchial pneumonia over 3 days
Due to nephritis/chronic over 3 days

Due to _____
Other conditions arteriosclerotic
(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)
(b) Did injury occur in or about home, on farm, in industrial place, in public place?

While at work? _____ (Specify type of place) (a) Means of injury _____
23. Signature Walter Bush (M. D. or other) _____
Address St Joe Hosp Date signed 12/5/43

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

SUPPLEMENTARY

MOTHER FATHER

