

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.

DEPARTMENT OF COMMERCE

BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No.

15669
15669

Registrar's No.

9

Registration District No.

339

Primary Registration District No.

6149

1. PLACE OF DEATH:

(a) County Stoddard
 (b) City or town Rural - Duck Creek
(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 _____ 70 years
years, months or days

3. (a) PRINT FULL NAME Huldah J. Hickman

8. (b) If veteran, name war _____ 8. (c) Social Security No. _____

4. Sex Female 5. Color or race White
 6. (a) Single, widowed, married, divorced, widowed
 6. (b) Name of husband or wife Monroe Hickman
 6. (c) Age of husband or wife if alive _____ years
 7. Birth date of deceased Oct. 2 1862
(Month) (Day) (Year)

8. AGE: Years 80 Months 6 Days 19 If less than one day _____ hr. _____ min.

9. Birthplace Obion Co. Tenn.
(City, town, or county) (State or foreign country)

10. Usual occupation Housekeeper

11. Industry or business _____

MOTHER FATHER
 12. Name _____
 13. Birthplace Not known
(City, town, or county) (State or foreign country)
 14. Maiden name Not known
 15. Birthplace _____
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature Huldah Hickman
 (b) Address Piquette Mo

17. (a) Burial (b) Date thereof Apr. 23 1943
(Burial, cremation, or removal) (Month) (Day) (Year)
 (c) Place: burial or cremation Pleasant Grove

18. (a) Signature of funeral director Pleasant Morgan
 (b) Address Piquette Mo

19. (a) 4-29-43 (b) J. H. Steinhilber
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Stoddard
 (c) City or town Rural -
(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.? _____ years

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 21
 year 1943 hour 2 minute 0 P. M.

21. I hereby certify that I attended the deceased from _____
 1943 to April 21, 1943
 that I last saw him alive on April 20, 1943
 and that death occurred on the date and hour stated above.

Immediate cause of death arterio
sclerosis

Due to arterio sclerosis / aged and
Paralysis

Due to _____

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

Major findings: Of operations
 Of autopsy Yes

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 E. P. Elmer (M. Director)
 Address Piquette Mo Date signed _____

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically

1132

RECEIVED

District Health Office No. 2,

District File Number 543-609

Date Filed 5-6-48

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 Lloyd S Morgan

Licensed Embalmer No. 3361

P. O. Address Adonai 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.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 15669
Registrar's No. 9

Registration District No. 339

Primary Registration District No. 6149

1. PLACE OF DEATH:

(a) County Stoddard
(b) City or town 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)
In this community 70 yrs.
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 Huldah J. Hickman

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

4. Sex F 5. Color or race W 6. (a) Single, widowed, married, divorced W

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

7. Birth date of deceased Oct 2 1873
(Month) (Day) (Year)

8. AGE: Years 80 Months 6 Days _____ If less than one day _____ min.

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

10. Usual occupation _____

11. Industry or business _____

12. Name _____

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

14. Maiden name _____

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

16. (a) Informant _____

(b) Address _____

17. (a) _____ (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)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April Day 12 Year 1943 Hour _____ 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 arterio sclerosis Duration _____

Due to advanced age and paralysis

Due to Paralysis

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)

(b) 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 E. J. ... (M. D. or other) _____

Address _____ Date signed _____

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

MOTHER FATHER

SUPPLEMENTARY

S-15669