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

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

*O. N. G. E. Cooper*  
MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. 43244

FILED JAN 1 02 1944

Registration District No. \_\_\_\_\_

Primary Registration District No. 5908

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

1. PLACE OF DEATH:

(a) County Remiscot

(b) City or town Holland Rural  
(If outside city or town limits, write "RURAL" and name of township)

(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 \_\_\_\_\_ (Specify whether)

In this community 21 years (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Remiscot

(c) City or town Holland Rural  
(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 Bessie Hicks

3. (b) If veteran, name war no

3. (c) Social Security No. none

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month November 11th  
year 1943 hour 6:00 minute \_\_\_\_\_ A. M.

4. Sex Female 5. Color or race White

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

6. (b) Name of husband or wife J. A. Hicks 6. (c) Age of husband or wife if alive 57 years

7. Birth date of deceased: January 1, 1901  
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from Oct 14 1943, to Nov 11 1943;  
that I last saw her alive on Oct 16 1943;  
and that death occurred on the date and hour stated above.

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

42 10 10 \_\_\_\_\_ hr. \_\_\_\_\_ min.

Immediate cause of death: Epidermoid Carcinoma

Due to \_\_\_\_\_

Due to \_\_\_\_\_

9. Birthplace: \_\_\_\_\_ (City, town, or county) Kentucky (State or foreign country)

Other conditions (Include pregnancy within 3 months of death) \_\_\_\_\_

Major findings: \_\_\_\_\_

Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

10. Usual occupation Housewife

11. Industry or business none

MOTHER FATHER

12. Name Don't know

13. Birthplace Don't know 9 (City, town, or county) (State or foreign country)

14. Maiden name Don't know

15. Birthplace Don't know 9 (City, town, or county) (State or foreign country)

PHYSICIAN

Underline the cause to which death should be charged statistically.

531-

16. (a) Informant J. A. Hicks

(b) Address Holland, Mo

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? \_\_\_\_\_

(c) Place: burial or cremation Holland, Sanfordsburg, Mo

18. (a) Signature of funeral director Curran and Co

(b) Address State, Missouri Box 126

19. (a) 1-4-44 (b) C. G. Lumbaug  
(Date received local registrar) (Registrar's signature)

While at work? \_\_\_\_\_ (Specify type of place)

(c) Means of injury \_\_\_\_\_

23. Signature O. N. G. Cooper (M. D. or other) m.d.

Address Center Mo. Date signed 12-9-43

1201

12-43-325

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.

*not embalmed*

Signed..... *John W German*.....

Licensed Embalmer No. *4355*.....

P. O. Address. *Stale, Yms*.....

**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.**