

No. 2
-5-43
5-17-39
X36671

FILED MAR 16 1944
Registration District No. **79**

Primary Registration District No. **5346**

Registrar's No. _____

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

1. PLACE OF DEATH:

(a) County Dade

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

(c) Name of hospital or institution: 1501 N. Main St. Y.
(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 _____
(Specify whether years, months or days)

3. (a) PRINT FULL NAME Charles E. Nickman

3. (b) If veteran, name war no

3. (c) Social Security No. no

4. Sex Male **5. Color or race** White

6. (a) Single, widowed, married, 2 divorced, widowed

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

7. Birth date of deceased Oct 20 1869
(Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
<u>74</u>	<u>2</u>	<u>19</u>	hr. _____ min. _____

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

10. Usual occupation Carpenter

11. Industry or business _____

12. Name _____

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

14. Maiden name _____

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

16. (a) Informant _____

(b) Address _____

17. (a) Burial, cremation, or removal Burial **(b) Date thereof** 1-13-44
(Month) (Day) (Year)

(c) Place: burial or cremation Rice Cemetery

18. (a) Signature of funeral director Willard B. Egan

(b) Address Dadeville Mo

19. (a) 3-1-44 **(b)** W. E. Egan
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Dade **29**

(c) City or town Dadeville
(If outside city or town limits, write "RURAL")

(d) Street No. North Part of Dadeville
(If rural, give location)

(e) Citizen of foreign country? No (Yes or No)

If yes, name country None

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan day 8
year 1944 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 _____

Due to Heart Failure

Due to _____

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

Major findings:
Of operations _____

Of autopsy _____

ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED

Duration _____

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 W. E. Egan

Address 1-12 E. R. Date signed _____

RECEIVED

District Health Officer No. 6,

District File Number 344-292

Date Filed MAR 13 1944

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

Willard R. Erwin

Licensed Embalmer No. 3092

P. O. Address

Salina, 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, fact should be so stated above.

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. April

Registration District No. _____ Primary Registration District No. _____ Registrar's No. _____

1. PLACE OF DEATH:

(a) County Wade
(b) City or town Waderville
(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 _____ years, months or days) 72 yrs

3. (a) PRINT FULL NAME Charles E. 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 w

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

7. Birth date of deceased Oct. 20 1872
(Month) (Day) (Year)

8. AGE: Years 74 Months 2 Days 2 (If less than one day, min.)

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

10. Usual occupation Welder

11. Industry or business _____

MOTHER FATHER { 12. Name Hickman

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

14. Maiden name Hickman

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

16. (a) Informant A. Wright

(b) Address Waderville

17. (a) burial (b) Date thereof 12-13-44
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Rice Cemetery

18. (a) Signature of funeral director Willard B. Ender

(b) Address Bolivar mo

19. (a) 12-28-44 (b) Kyle Kirby
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State mo (b) County Wade
(c) City or town Waderville
(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 Jan Day 12 year 1944 hour _____ minute _____ M.

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

Immediate cause of death _____

Coronary atherosclerosis
Heart failure
Due to _____

Due to _____ 93d

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

Major findings: Of operations _____

Of autopsy _____

ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED

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 _____ (M. D. or other) _____
Address _____ Date signed _____

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

SUPPLEMENTARY INFORMATION REQUESTED

10820