

V. S. No. 2
 00M-2-43
 Rev. 5-17-39
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DEPARTMENT OF COMMERCE
 BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI
 STANDARD CERTIFICATE OF DEATH

State File No. _____
 Registrar's No. _____

Registration District No. 316

Primary Registration District No. 6075

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

1. PLACE OF DEATH:
 (a) County St. Francois
 (b) City or town Farmington RURAL St. Francois
(If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution:
Mo. State Hospital No. 4
(If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution 1 month 3 das.
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:
 (a) State Missouri (b) County Pemiscot 94
 (c) City or town Steele 0
(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 DELLA E. VICKREY
 (b) If veteran, name war No
 (c) Social Security No. None

MEDICAL CERTIFICATION
 20. DATE OF DEATH: Month June day 18
 year 1944 hour 11 minute 55 A. M.

4. Sex Female 5. Color or race White
 6. (a) Single, widowed, married, divorced Widowed
 (b) Name of husband or wife Dr. James Perry Bickrey 6. (c) Age of husband or wife if alive _____ years
 7. Birth date of deceased: October 16, 1889
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from May 15, 1944 19 to June 18, 1944 19
 that I last saw her alive on June 18, 1944 19
 and that death occurred on the date and hour stated above.

8. AGE: Years Months Days If less than one day
54 8 2 hr. _____ min.

Immediate cause of death Mans exhaustion Duration _____
 Due to _____
 Due to _____
 Other conditions (include pregnancy within 3 months of death) _____
 Major findings: Of operations _____
 Of autopsy No autopsy.

9. Birthplace Morris Chapel Tennessee
(City, town, or county) (State or foreign country)
 10. Usual occupation Housewife

PHYSICIAN _____
 Underline the cause to which death should be charged statistically.

11. Industry or business _____
 12. Name Thomas Meek
 13. Birthplace Tennessee
(City, town, or county) (State or foreign country)
 14. Maiden name Dora Perkins
 15. Birthplace Tennessee
(City, town, or county) (State or foreign country)

16. (a) Informant Records State Hospital No. 4
 (b) Address Farmington, Mo.
 17. (a) Burial (b) Date thereof 6-19-44
(Burial, cremation, or removal) (Month) (Day) (Year)
 (c) Place: burial or cremation Mt. Zion Cem., Steele, 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?
 While at work? _____ (Specify type of place)
 (e) Means of injury _____
 23. Signature [Signature] (M. D. or other) mlb
 Address 4608 N. Walnut Date signed 6-20-44

18. (a) Signature of funeral director German Funeral Home
 (b) Address Steele, Missouri
 19. (a) 6-29-44 (b) [Signature]
(Date received local registrar) (Registrar's signature)

1373

(Licensed Embalmer's Statement on Reverse Side)

Farmington, Mo.

RECEIVED

District Health Officer No. 4

District File Number 744-412

Date Filed 7-28-44

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..... *C. H. Coyle*

Licensed Embalmer No. 4184

P. O. Address Springton 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.