

FILED OCT 4 1944

Registration District No. 70

Primary Registration District No. 5463A

State File No. \_\_\_\_\_

Registrar's No. 61

1. PLACE OF DEATH:

(a) County Greene County  
(b) City or town Rt. 2, Springfield, Mo.  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
Rt. 2, Springfield  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 1 (Specify whether  
In this community Lifetime (Specify whether  
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Greene 39  
(c) City or town Rural 0  
(If outside city or town limits, write "RURAL")  
(d) Street No. Rt. 2, Springfield, Mo. 0  
(If rural, give location)  
(e) Citizen of foreign country? No (Yes or No)  
If yes, name country 0

3. (a) PRINT FULL NAME William Joseph Hicks

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, divorced Widower  
6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased March 20th, 1861  
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day  
83 4 17 hr. min.

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

10. Usual occupation Missionary Baptist Minister

11. Industry or business \_\_\_\_\_

12. Name John Hicks

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

14. Maiden name Emeline Garrett

15. Birthplace Dallas County, Mo. 0  
(City, town, or county) (State or foreign country)

16. (a) Informant Robert Hicks

(b) Address North View, Mo.

17. (a) Burial (b) Date thereof 8-9, 1944  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Welch Cemetery

18. (a) Signature of funeral director W. L. DUNN

(b) Address Springfield, Mo.

19. (a) 9/5/44 (b) Harland Harrison  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month August day 7th.  
year 1944 hour 11 minute 40 P. M.

21. I hereby certify that I attended the deceased from Unattended by physician  
that I last saw him alive on \_\_\_\_\_, 19\_\_\_\_  
and that death occurred on the date and hour stated above.

Immediate cause of death Senility

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

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

Other conditions 1628  
(Include pregnancy within 3 months of death)

Major findings:  
Of operations \_\_\_\_\_

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

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?  
(Specify type of place)

While at work? \_\_\_\_\_ (e) Means of injury \_\_\_\_\_

23. Signature D. W. Hardy local Registrar (M. D. or other)

Address Springfield Mo. Date signed 8/9/44

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

MOTHER FATHER

1246

**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.....

Licensed Embalmer No. *C. W. McE...*

P. O. Address. *2291*

**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.**