S. No. 2
M—5-42
. 5-17-39
I X32873

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED JUN 7 1945

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 17078

Registration District No. 138 Primary Registration District No. 5523 Registrar's No. 3

1. PLACE OF DEATH:

(a) County Hickory Green Twp
(b) City or town Hemo (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 20 years (years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Hickory 43
(c) City or town Hemo (Rural) Green (If outside city or town limits, write "RURAL")
(d) Street No. (If rural, give location)
(e) Citizen of foreign country? 0 (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME Chas E Quick

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

4. Sex Male
5. Color or race W
6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife Dona Quick
6. (c) Age of husband or wife if alive 56 years
7. Birth date of deceased 12 (Month) 11 (Day) 1872 (Year)

8. AGE:

Years	Months	Days	If less than one day
72	4	10	hr. min.

9. Birthplace Miller Co. (City, town, or county) Mo (State or foreign country)
10. Usual occupation Farmer
11. Industry or business
FATHER
12. Name Baylth H Quick
13. Birthplace (City, town, or county) Mo (State or foreign country)
MOTHER
14. Maiden name Leah Capps
15. Birthplace Farmington (City, town, or county) Ill (State or foreign country)
16. (a) Informant Donna Quick
(b) Address Hemo, Mo Hermitage
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 4-24-45 (Month) (Day) (Year)
(c) Place: burial or cremation Antioch Cemetery
18. (a) Signature of funeral director Gilbert Hathaway
(b) Address Wheatland, Mo
19. (a) June 2-45 (Date received local registrar) (b) Mary K Carlstrom (Registrar's signature)

MEDICAL CERTIFICATION

20. **DATE OF DEATH:** Month April day 21 year 1945 hour 9 minute 10 P M.

21. I hereby certify that I attended the deceased from April 21, 1945 to April 21, 1945 that I last saw him alive on April 21, 1945 and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Myocardial Failure	3 hours
Due to	
Due to	
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? (Specify type of place)
While at work? (e) Means of injury

23. Signature W. H. R. Easton (M. D. or other) DO
Address Neuablean, Mo Date signed May 29, 1945

1094

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED
Di... ...th Officer No. 7,
Di... ... 5-45-481
Date Filed 6-6-45

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 Chas Gilbert Hathaway

Licensed Embalmer No. 4267

P. O. Address Wheatland, 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.

S. No. 2B
—3-45
X43880

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. June

Registration District No. 138 Primary Registration District No. 5523 Registrar's No. 3

1. PLACE OF DEATH:

(a) County Hickory

(b) City or town Rural — Green Twp
(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)

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 Chas E. Quick

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 M

6. (b) Name of husband or wife

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

7. Birth date of deceased Dec (Month) 11 (Day) 1848 (Year)

8. AGE: Years 72 Months 5 Days 10 If less than one day hr. min.

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

10. Usual occupation

11. Industry or business

FATHER
12. Name
13. Birthplace (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name
15. Birthplace (City, town, or county) (State or foreign country)

16. (a) Informant

(b) Address

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

(c) Place: burial or cremation

18. (a) Signature of funeral director

(b) Address

19. (a) (Date received local registrar) (b) (Registrar's signature)

MEDICAL CERTIFICATION

20. **DATE OF DEATH:** Month April Day 21 year 1945 hour minute M.

21. I hereby certify that I attended the deceased from April 21, 1945, to April 21, 1945 that I last saw him alive on April 21, 1945 and that death occurred on the date and hour stated above.

Immediate cause of death Myocardial Failure

Due to Heart Block

Due to

Other conditions (Include pregnancy within 3 months of death)

Major findings:
Of operations

Of autopsy

ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED 95a

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 W. H. R. Easton (M. D. or other) MD

Address Neanblean, Mo Date signed June

SUPPLEMENTARY

17078