No. 2
-8-43
-17-39
X37823

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED OCT 15 1945

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 30370

Registration District No. 74 Primary Registration District No. 5293 Registrar's No. 33-46

1. PLACE OF DEATH:

(a) County Clinton

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

(c) Name of hospital or institution: / m-p
(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 Entire Life

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Clinton 25

(c) City or town Rural, Atchison Twp. 0
(If outside city or town limits, write "RURAL")

(d) Street No. 0
(If rural, give location)

(e) Citizen of foreign country? no (Yes or No) 0
If yes, name country

3. (a) PRINT FULL NAME WILLIAM-LYKINS

3. (b) If veteran, name war ..... 3. (c) Social Security No. 496-01-8582

4. Sex Male 0 5. Color or race White 6. (a) Single, widowed, married, divorced 709

6. (b) Name of husband or wife Sarah L. Lykins 6. (c) Age of husband or wife if alive ..... years

7. Birth date of deceased Feb. (Month) 18 (Day) 1875 (Year)

8. AGE:	Years	Months	Days	If less than one day
	70	6	13	..... hr. ..... min.

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

10. Usual occupation Carpenter

11. Industry or business

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

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

16. (a) Informant Sarah Lykins
(b) Address Gower Mo

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept. 3-40 (Month) (Day) (Year)
(c) Place: burial or cremation Allen Cemetery

18. (a) Signature of funeral director H. A. Sullins
(b) Address Gower Mo.

19. (a) 9-5-45 (Date received local registrar) (b) Mrs A C Hartell (Registrar's signature)

MEDICAL CERTIFICATION

20. **DATE OF DEATH:** Month Sept day 1st year 1945 hour 9 P.M. minute ..... M.

21. I hereby certify that I attended the deceased from about 2 yr ....., 19...., to ....., 19....; that I last saw him alive on 9-1-, 1945 and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Coronary occlusion	
Due to arteriosclerosis	
Due to	
Other conditions (Include pregnancy within 3 months of death)	

Major findings:
Of operations .....
Of autopsy 940

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 J. C. Starks MD ~~(M. D. or other)~~
Address Gower, Mo Date signed 9-3-45

1085

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Officer No. 11,
District File Number
Date Filed

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 H. A. Sullins

Licensed Embalmer No. 1738

P. O. Address.....

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.

. No. 2B
—8-21-41
I X29288

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No.

Registration District No. 74 Primary Registration District No. (5293) Registrar's No.

1. PLACE OF DEATH:

(a) County Clinton Atchison Twp

(b) City or town (Gower - 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 years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State (b) County

(c) City or town Rural - Atchison Twp
(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 Wm Lykins

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

6. (b) Name of husband or wife

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

7. Birth date of deceased Feb 18 1898
(Month) (Day) (Year)

8. AGE: Years 70 Months 6 Days 3 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 Sept day
year 1945 hour minute M.

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

	Duration
Immediate cause of death	
Due to	
Due to	
Other conditions (Include pregnancy within 3 months of death)	

Major findings:
Of operations
Of autopsy

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

SUPPLEMENTARY

30370