

S. No. 2  
M-5-42  
5-17-39  
X32873

DEPARTMENT OF COMMERCE

STATE BOARD OF HEALTH OF MISSOURI

24544

**FILED** AUG 9 1946 **STANDARD CERTIFICATE OF DEATH**

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

Registration District No. 272

Primary Registration District No. 4603

Registrar's No. 46

1. PLACE OF DEATH

(a) County Pemissat

(b) City or town Stale  
(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 70 yrs  
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Pemissat

(c) City or town Stale  
(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 Lillie Hopkins (Hicks)

3. (b) If veteran, No name war \_\_\_\_\_

3. (c) Social Security No. \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 16  
year 1946 hour 6 minute \_\_\_\_\_ P. M.

21. I hereby certify that I attended the deceased from June 1  
1946 to June 16, 1946  
that I last saw h. e. r. alive on June 16, 1946  
and that death occurred on the date and hour stated above.

4. Sex F 5. Color or race Cal.

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

6. (b) Name of husband or wife Will Hicks

6. (c) Age of husband or wife if alive 60 years

7. Birth date of deceased: \_\_\_\_\_ (Month) (Day) (Year)

Immediate cause of death Respiratory failure Duration \_\_\_\_\_

8. AGE: Years abt 69 Months \_\_\_\_\_ Days \_\_\_\_\_ If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

Due to Hypertension & Cerebral thrombosis

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

9. Birthplace: \_\_\_\_\_ (City, town, or county) (State or foreign country)

10. Usual occupation Housewife

Other conditions (Include pregnancy within 3 months of death) \_\_\_\_\_

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

12. Name unknown

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

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

14. Maiden name \_\_\_\_\_

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

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

16. (a) Informant Will Hicks

(b) Address Stale 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? \_\_\_\_\_

17. (a) Buried (b) Date thereof 7-20-46  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Stale MO

While at work? \_\_\_\_\_ (Specify type of place) (a) Means of injury \_\_\_\_\_

18. (a) Signature of funeral director German and Co.

(b) Address Stale MO

19. (a) 90-46 (b) [Signature]  
(Date received local Registrar) (Registrar's signature)

23. Signature J. M. Callahan M.D. M. D. or other \_\_\_\_\_  
Address Stale MO Date signed 8/3/46

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

8  
3

8-46-188

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**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.....

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.**