

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

2-2
4-43
7-39
5-6671

30786

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. _____

FILED SEP 17 1946

Registration District No. B 7

Primary Registration District No. 5591

Registrar's No. _____

1. PLACE OF DEATH:

(a) County Jefferson County

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

(c) Name of hospital or institution: 3
(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 _____ (Specify whether years, months or days)

3. (a) PRINT FULL NAME HAROLD HICKMAN

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

4. Sex M 2/ 5. Color or race C

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

6. (b) Name of husband or wife Irene 6. (c) Age of husband or wife if alive 39 years

7. Birth date of deceased Sept. 9 1900
(Month) (Day) (Year)

8. AGE: Years 39 Months 11 Days _____ If less than one day hr. _____ min. _____

9. Birthplace Springfield Ill. /
(City, town, or county) (State or foreign country)

10. Usual occupation Laborer

11. Industry or business _____

MOTHER FATHER

12. Name Pastelle Hickman

13. Birthplace Springfield Ill. /
(City, town, or county) (State or foreign country)

14. Maiden name Unavailable

15. Birthplace Unavailable 7
(City, town, or county) (State or foreign country)

16. (a) Informant Irene Hickman
(b) Address 4471 Page Blvd.

17. (a) _____ (b) Date thereof 9-3-46
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Unknown

18. (a) Signature of funeral director Chas. J. Gates
(b) Address 4107 Finney Ave.

19. (a) 9/3/46 (b) BT Willis M. Kessler
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State K (b) County 502

(c) City or town _____
(If outside city or town limits, write "RURAL") 0

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

(e) Citizen of foreign country? No (Yes or No)

If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept day 3rd
year 1946 hour _____ minute 3:00 AM.

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____;

that I last saw him _____ alive on _____, 19____;

and that death occurred on the date and hour stated above.

Immediate cause of death Verdict of Coroner
By accidental shot given
wound by his self.

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: 50

(a) Accident, suicide, or homicide (specify)

(b) Date of occurrence 9/3/46

(c) Where did injury occur? In Woods.
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place?
On his farm

While at work? _____ (Specify type of place) (e) Means of injury gun shot

Signature T. B. Edwards (M. D. or other) Coroner

Address Order 17111 Mo Date signed 9/3/46

141

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.....

Chas. J. Gat es , Registered Apprentice No.....

working under my personal supervision.

Signed.....

Licensed Embalmer No. 1825

P. O. Address. 4107 Finney Ave.

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.

Registration District No. 159 Primary Registration District No. 5591

1. PLACE OF DEATH:

(a) County Jefferson

(b) City or town Jefferson
(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

3. (a) PRINT FULL NAME Harold Dickman

3. (b) If veteran, name war _____

3. (c) Social Security No. _____

4. Sex m

5. Color or race B

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

6. (b) Name of husband or wife _____

6. (c) Age of husband or wife if alive 39 years

7. Birth date of deceased Sept 9 1940
(Month) (Day) (Year)

8. AGE: 39 Years 3 Months 11 Days (If less than one day, hr. min.)

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

10. Usual occupation laborer

11. Industry or business laborer

12. Name Pastelle Dickman

13. Birthplace Springfield Ill
(City, town, or county) (State or foreign country)

14. Maiden name unavailable

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

16. (a) Informant Irene Dickman

(b) Address 4471 Page Blvd

17. (a) _____ (b) Date thereof 9-3-46
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation unknown

18. (a) Signature of funeral director Chas J Gatas

(b) Address 4107 Finneyville St Louis

19. (a) 9/2/46 (b) Fathead Marsden
(Date received loc (Registrar)) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Jefferson

(c) City or town _____
(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 _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept day 13 year 1946 hour _____ minute _____ M.

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

Immediate cause of death _____

Duration _____

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)

(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 _____ (M. D. or other)

Address _____ Date signed _____

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

SUPPLEMENTARY

30786