

U.S. No. 2
FORM-5-43
REV. 5-17-39
I X36671

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **16918**
Registrar's No. **126**

FILED JUN 14 1947
Registration District No. **177**

Primary Registration District No. **3016**

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

1. PLACE OF DEATH

(a) County Cole

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

(c) Name of hospital or institution: St. Marys Hospital
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 25 years (Specify whether years, months or days)

In this community 25 years

3. (a) PRINT FULL NAME Sophia A. Fickoff

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

4. Sex Female 5. Color White 6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Frank 6. (c) Age of husband or wife if alive 61 years

7. Birth date of deceased July 20 1889
(Month) (Day) (Year)

8. AGE: Years 56 Months 10 Days 7 If less than one day hr. _____ min. _____

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

10. Usual occupation Housework

11. Industry or business At home

12. Name Frank Mason 9

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

14. Maiden name Unknown Bryant 9

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

16. (a) Informant Frank Fickoff

(b) Address Cedar City, Mo.

17. (a) Buried (b) Date thereof 5-29-47
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Union Hill

18. (a) Signature of funeral director J. J. Swine

(b) Address 709 Jefferson

19. (a) 6-24-47 (b) R. P. Davis M.D.
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Callaway 14

(c) City or town Cedar City 10
(If outside city or town limits, write "RURAL")

(d) Street No. 1 block east of Baptist Church
(If rural, give location)

(e) Citizen of foreign country? No. (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 27
year 1947 hour 6 minute 30 M.

21. I hereby certify that I attended the deceased from May 24, 1947, to May 27, 1947; that I last saw her alive on May 27, 1947; and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral Haemorrhage.

Due to Hypertensive Heart Disease

Due to _____

Other conditions (include pregnancy within 3 months of death) _____

Major findings: B.D.
Of operations _____

Of autopsy _____

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) (c) Means of injury 0

23. Signature L. B. Klella (M. D. or other M.D.)
Address Jefferson City, Mo. Date signed 5-27-47

RECEIVED
District Health Officer No. 9,
District File Number
Date Filled 6/13/47

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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.....

Paul J. Zimmerman....., Registered Apprentice No. *781*
working under my personal supervision.

Signed.....
J. H. Anderson

Licensed Embalmer No. *3641*

P. O. Address.....
Genoa

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.