

FILED JUN 8 1950

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

16245

State File No.

BIRTH NO. _____ REG. DIST. NO. 82 PRIMARY REG. DIST. NO. 3017 Registrar's No. 56

1. PLACE OF DEATH a. COUNTY COOPER		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE MISSOURI b. COUNTY COOPER	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN BOONVILLE		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN BOONVILLE	
c. LENGTH OF STAY (in this place) 67 yrs			
d. FULL NAME OF HOSPITAL OR INSTITUTION ST. JOSEPH'S HOSPITAL		d. STREET ADDRESS (If rural, give location) 810 PORTER	

3. NAME OF DECEASED (Type or Print) a. (First) **WILLIAM** b. (Middle) **NELSON** c. (Last) **HICKMAN**

4. DATE OF DEATH (Month) (Day) (Year) **MAY 28-1950**

5. SEX **MALE** 6. COLOR OR RACE **NEGRO** 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) **WIDOWED** 8. DATE OF BIRTH **JUNE 20-1882** 9. AGE (In years last birthday) **67** IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) **LABORER** 10b. KIND OF BUSINESS OR INDUSTRY **ICE HANDLER** 11. BIRTHPLACE (State or foreign country) **BOONVILLE - MISSOURI** 12. CITIZEN OF WHAT COUNTRY? **U.S.A.**

13a. FATHER'S NAME **WILLIAM HICKMAN** 13b. MOTHER'S MAIDEN NAME **SARAH JONES** 14. NAME OF HUSBAND OR WIFE **HENRIETTA HICKMAN**

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) **NO** (If yes, give year or dates of service) **NONE** 16. SOCIAL SECURITY NO. **NONE** 17. INFORMANT'S SIGNATURE OR NAME **WILLIAM HICKMAN-BOONVILLE MO.** ADDRESS

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) **Irregular Fibrillation**

ANTECEDENT CAUSES (b) **Chr. Degen. Myocarditis**

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. (c) **Diabetes**

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH **2 hrs.**

19a. DATE OF OPERATION _____ 19b. MAJOR FINDINGS OF OPERATION _____ 20. AUTOPSY? YES NO

21a. ACCIDENT SUICIDE HOMICIDE (Specify) _____ 21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) _____ 21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) _____ 21e. INJURY OCCURRED WHILE AT WORK NOT WHILE AT WORK 21f. HOW DID INJURY OCCUR?

22. I, hereby certify that I attended the deceased from May 20, 1950, to May 28, 1950, that I last saw the deceased alive on May 28, 1950, and that death occurred at 2:00 m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) **J. L. DeLoach, M.D.** 23b. ADDRESS **Boonville Mo** 23c. DATE SIGNED **5/31/50**

24a. BURIAL, CREMATION, REMOVAL (Specify) **BURIAL** 24b. DATE **JUNE 2-1950** 24c. NAME OF CEMETERY OR CREMATORY **CITY CEMETERY** 24d. LOCATION (City, town, or county) (State) **BOONVILLE - MO.**

DATE REC'D BY LOCAL REG. **May 31-1950** REGISTRAR'S SIGNATURE **D. Cooper** 381 25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS **STEGNER FUNERAL HOME-BOONVILLE MO.**

WRITE PLAINLY--USING UNFADING BLACK INK--MAKE A PERMANENT RECORD

0277

RECEIVED

JUN 5

District Health Officer No. 8,

District File Number

Date Filed

6/7/50

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

Student Embalmer No.

working under my personal supervision.

Signed

James W. Segner

Signed.....
Student Embalmer

Licensed Embalmer No. #8 3780

P. O. Address BOONVILLE 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.