

Health,  
Welfare  
Public  
Service

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

58-013238  
STATE FILE NUMBER

FILED APR 28 1958

Registration District No. 38 Primary Registration District No. 3006 Registrar's No. 183

300  
-57

|   |                           |  |  |   |   |
|---|---------------------------|--|--|---|---|
| 1. PLACE OF DEATH<br>a. COUNTY Boone  |                           |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE Missouri b. COUNTY Boone |   |   |
| b. CITY (If outside corporate limits, give TOWNSHIP only)<br>Columbia   |                           | Inside Limits<br>Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>   | c. CITY OR TOWN<br>Columbia  |   | Inside Limits<br>Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>              |
| c. FULL NAME OF (If NOT in hospital, give location)<br>HOSPITAL OR INSTITUTION<br>110 Sexton Rd.  |                           | Length of stay in 1b<br>37 Yrs.  | d. STREET ADDRESS<br>110 Sexton Rd.  |   | Reside on Farm<br>Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>             |
| 3. NAME OF DECEASED (Type or print)<br>First Middle Last<br>WILLIAM MIKE HICKERSON  |                           |  | 4. DATE OF DEATH<br>Month Day Year<br>April 17, 1958   |   |   |
| 5. SEX<br>Male  | 6. COLOR OR RACE<br>White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br>Sept. 17, 1911   |   | 9. AGE (In years last birthday)<br>46   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br>Auto Repair Service  |                           | 10b. KIND OF BUSINESS OR INDUSTRY<br>Auto Repair Service   | 11. BIRTHPLACE (City and state or country)<br>Tebbetts, Missouri   |   | 12. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  |
| 13a. FATHER'S NAME<br>J.R. Hickerson  |                           | 13b. MOTHER'S MAIDEN NAME<br>Sophie Scott  |  | 14. NAME OF HUSBAND OR WIFE<br>Martha Fern Martin                   |   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)<br>NO   |                           | 16. SOCIAL SECURITY NO.<br>490-07-0472   |  | 17. INFORMANT Address<br>Mrs. William Mike Hickerson, Columbia, Mo. |   |
| 18. CAUSE OF DEATH (Enter only one cause per line in (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <i>astropaytona, left cerebrum</i><br>Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) <i>The above tumor was inoperable.</i><br>DUE TO (c) <i>at Mayo Clinic in Dec. 1955</i> |                           |  |  |   | INTERVAL BETWEEN DEATH AND DEATH  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART-I (a)   |                           |  |  |   | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>   |                           |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)<br>1930                       |   |   |
| 20c. TIME OF INJURY<br>Hour Month, Day, Year<br>a.m. p.m.   |                           |  |  |   |   |
| 20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |                           | 20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)   |  | 20f. CITY, TOWN, OR LOCATION COUNTY STATE                           |   |
| 21. I attended the deceased from <i>Mar 29 1956</i> to <i>Apr 17 1958</i> and last saw her alive on <i>Apr. 16, 1958</i><br>Death occurred at <i>2:45 p</i> m on the date stated above; and to the best of my knowledge, from the causes stated.  |                           |  |  |   |   |
| 22a. SIGNATURE (Deceased or title)<br><i>James M Baker M.D.</i>   |                           |  | 22b. ADDRESS<br><i>Columbia, Mo.</i>   |   | 22c. DATE SIGNED<br><i>Apr. 19 1958</i>   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br>Burial   |                           | 23b. DATE<br>Apr. 19, 1958   | 23c. NAME OF CEMETERY OR CREMATORY<br>Memorial Park Cemetery   |   | 23d. LOCATION (City, town, or county) (State)<br>Columbia, Missouri.                              |
| 24. FUNERAL DIRECTOR ADDRESS<br>Parker Funeral Service, Columbia, Mo.   |                           |  | 25. DATE RECD. BY LOCAL REG.<br>April 19 1958  | 26. REGISTRAR'S SIGNATURE<br><i>Mrs R.E. Palmer</i>                 |   |

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE  
MEDICAL CERTIFICATION

All diseases in Part I must be causally related.

APR 30 1953

MAY 4 1953

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.

Student .....  
Signature of Student Embalmer

Signed *J. P. Kelly* .....

Licensed Embalmer No. *4897* .....

P. O. Address *Columbia, 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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.  
If this body is not embalmed, fact should be so stated above.