

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

58-033502

STATE FILE NUMBER

Registration District No. 209 Primary Registration District No. 3043 Registrar's No. 298

1. PLACE OF DEATH a. COUNTY <u>Marion</u>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Marion</u>		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Hannibal</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>Hannibal</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>St. Elizabeth Hospital</u>		Length of stay in 1b	d. STREET ADDRESS (If outside, give location) <u>621 Bird Street</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>OMER</u> Middle <u>HICKMAN</u> Last <u>HICKMAN</u>			4. DATE OF DEATH Month <u>September</u> Day <u>11</u> Year <u>1958</u>		
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>October 21, 1958</u>	9. AGE (In years last birthday) <u>66</u>	IF UNDER 1 YEAR Months <u>10</u> Days <u>11</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Engineer</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>Rock Island R.R.</u>	11. BIRTHPLACE (City and state or country) <u>Ashley Missouri</u>		12. CITIZEN OF WHAT COUNTRY? <u>U S A</u>	
13a. FATHER'S NAME <u>Lou Hickman</u>		13b. MOTHER'S MAIDEN NAME <u>Florence Worthington</u>		14. NAME OF HUSBAND OR WIFE <u>Effie Schanbacher Hickman</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>707 16 7270</u>	17. INFORMANT Address <u>Mrs. Omer Hickman Hannibal Missouri</u>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Ruptured Aneurysms of Abdominal Aorta</u>					INTERVAL BETWEEN ONSET AND DEATH <u>2 hours.</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) <u>451X</u>					
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? 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.)			
20c. TIME OF INJURY Hour _____ Month, Day, Year _____ a.m. _____ p.m. _____					
20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE <input type="checkbox"/> WORK AT WORK		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 <u>9-11-58</u> to <u>9-11-58</u> and last saw her/him alive on <u>9-11-58</u> Death occurred at <u>750 P.</u> on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE <u>[Signature]</u> (Degree or title)			22b. ADDRESS <u>M.D., 100 N. Sixth, Hannibal, Mo.</u>		22c. DATE SIGNED <u>9-13-58</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>9/13/1958</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Grand View Burial Park</u>		23d. LOCATION (City, town, or county) (State) <u>Hannibal Missouri</u>	
24. FUNERAL DIRECTOR <u>W. Crawford Smith, Hannibal Missouri</u>		ADDRESS	25. DATE RECD. BY LOCAL REG. <u>9-16-1958</u>	26. REGISTRAR'S SIGNATURE <u>Dr. E. M. Luckely H. C. Fisher</u>	

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

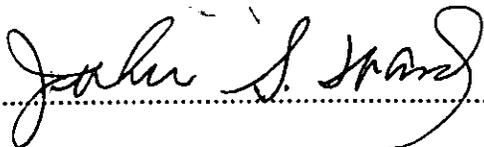
Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related.

RECEIVED SEP 24 1958  
MARION CO. HEALTH DEPT.  
DATE FILED SEP 24 1958

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  .....

Licensed Embalmer No.....4540....  
P. O. Address...Hannibal Missouri

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.