

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-017514

STATE FILE NUMBER

FILED JUN 2 1959 Registration District No. 138 Primary Registration District No. Registrar's No. 23

S. 300
1-57

1. PLACE OF DEATH a. COUNTY <u>Hickory</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Hickory</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Cross Timbers Township</u> Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		c. CITY OR TOWN <u>Cross Timbers Township</u> Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>1/2 mile East Cross Timbers Altogether</u> Length of stay in lb <u>043</u>		d. STREET ADDRESS (If outside, give location) <u>1/2 mile East Cross Timbers</u> Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First <u>Joel</u> Middle <u>Newman</u> Last <u>Hickman</u>			4. DATE OF DEATH Month <u>May</u> Day <u>20</u> Year <u>1959</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 checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 2-1876</u>	9. AGE (In years last birthday) <u>82</u> IF UNDER 1 YEAR Months <u>11</u> Days <u>2</u> IF UNDER 24 HRS. Hours <u></u> Min. <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FARMING</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>SELF Employed</u>	11. BIRTHPLACE (City and state or country) <u>Cross Timbers MO</u>	12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	

13a. FATHER'S NAME <u>J. C. Hickman</u>		13b. MOTHER'S MAIDEN NAME <u>Martha Hicks</u>		14. NAME OF HUSBAND OR WIFE <u>Charlotte 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>495-42-8004</u>	17. INFORMANT Address <u>Bert Hickman - Cross Timbers MO</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>Cerebral Thrombosis</u>			INTERVAL BETWEEN ONSET AND DEATH <u>24 hrs</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>age arterio sclerosis</u>			
DUE TO (c) <u>Carcinoma of bowels 1538</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Operation for cancer of bowels 6 weeks before death</u>			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 (18).)		
20c. TIME OF INJURY Hour <u></u> Month, Day, Year <u></u> a.m. <u></u> p.m. <u></u>	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 <u>May 18</u> , to <u>May 19</u> and last saw <u>her</u> alive on <u>May 19 1959</u> Death occurred at <u>11:50 A</u> m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <u>Al Neuwins MD</u>		22b. ADDRESS <u>Hermutge</u>	
22c. DATE SIGNED <u>May 24-59</u>			

23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>5-22-1959</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Cross Timbers Cemetery Cross Timbers MO</u>	23d. LOCATION (City, town, or county) (State) <u></u>
24. FUNERAL DIRECTOR ADDRESS <u>Silbert H. Harvey - Westland 540</u>		25. DATE RECD. BY LOCAL REG. <u>May 30-1959</u>	26. REGISTRAR'S SIGNATURE <u>May Johnson</u>

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.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE
MEDICAL CERTIFICATION

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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, Student Embalmer No. working under my personal supervision.

Student
Signature of Student Embalmer

Signed *Chas. Gilbert Hathaway*.....

Licensed Embalmer No. *4267*.....

P. O. Address *Wheatland, W. Va.*

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.