

# FRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

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Registration District No. 333 Primary Registration District No. 3074 Registrar's No. 232 STATE FILE NUMBER

INDEXED

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|--|--|---|---|---|---|--|---|--|--|--|--|------------------------------|--|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Scott</u>  |  |   |   | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <u>MO</u> b. COUNTY <u>NEW MADRID</u>                     |   |  |   |  |  |  |  |                              |  |
| b. CITY (If outside corporate limits, give TOWNSHIP only)<br>OR TOWN <u>Sikeston</u>   |  | Length of stay in 1b  |   | c. CITY OR TOWN <u>NEW MADRID</u>   |   | 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 <u>Mo. Della Comm Hosp.</u>   |  |   | Inside Limits<br>Yes <input type="checkbox"/> No <input type="checkbox"/> |   | d. STREET ADDRESS (If outside, give location)<br><u>840 BRUSH PRAIRIE</u> |  | Reside on Farm<br>Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> |  |  |  |  |                              |  |
| 3. NAME OF DECEASED (Type or print)<br>First <u>Robert</u> Middle <u>Allen</u> Last <u>Hicks</u>   |  |   |   | 4. DATE OF DEATH<br>Month <u>12</u> Day <u>13</u> Year <u>59</u>  |   |  |   |  |  |  |  |                              |  |
| 5. SEX <u>M</u>  |  | 6. COLOR OR RACE <u>E</u>   |   | 7. Married <input type="checkbox"/> Never Married <input type="checkbox"/><br>Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/> |   | 8. DATE OF BIRTH <u>2-17-1894</u>  |   | 9. AGE (last birthday) <u>65</u>   |  | IF UNDER 1 YEAR<br>Months Days Hours Min.  |  | IF UNDER 24 HR<br>Hours Min. |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>FARMING</u>  |  |   |   | 10b. KIND OF BUSINESS OR INDUSTRY<br>—  |   |  |   | 11. BIRTHPLACE (City and state or country)<br><u>NEW MADRID MO. U.S.A.</u> |  | 12. CITIZEN OF WHAT COUNTRY  |  |                              |  |
| 13a. FATHER'S NAME<br><u>TOM HICKS</u>   |  |   |   | 13b. MOTHER'S MAIDEN NAME<br><u>JOSEPHINE LA SEAR</u>   |   |  |   | 14. NAME OF HUSBAND OR WIFE<br><u>GERTRUDE HICKS</u>                       |  |  |  |                              |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)   |  |   |   | 16. SOCIAL SECURITY NO.<br><u>496-40-2299</u>   |   | 17. INFORMANT<br><u>ROBERT RILEY NEW MADRID</u>                                      |   |  |  | Address  |  |                              |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>ARTERIO SCLEROTIC HEART DIS.</u>  |  |   |   |   |   |  |   |  |  | INTERVAL BETWEEN ONSET AND DEATH   |  |                              |  |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.<br>DUE TO (b) _____<br>DUE TO (c) _____   |  |   |   |   |   |  |   |  |  |  |  |                              |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)<br><u>Ess. HYPERTENSION</u>  |  |   |   |   |   |  |   |  |  | PART III. If deceased was female was there a pregnancy in last 90 days.<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown |  |                              |  |
| 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.)  |   |  |   |  |  |  |  |                              |  |
| 20c. TIME OF INJURY<br>Hour _____ a.m. _____ p.m.  |  | Month, Day, Year  |   |   |   |  |   |  |  |  |  |                              |  |
| 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>6-19-59</u> to <u>12-12-59</u> and last saw <sup>him</sup> alive on <u>12-12-59</u><br>Death occurred at <u>12-13-59, 2:59 am</u> on the date stated above, and to the best of my knowledge, from the causes stated. |  |   |   |   |   |  |   |  |  |  |  |                              |  |
| 22a. SIGNATURE<br><u>Carl G. Topf M.D.</u> (Degree of title)   |  |   |   | 22b. ADDRESS<br><u>SIKESTON MO.</u>   |   |  |   | 22c. DATE SIGNED<br><u>12-14-59</u>  |  |  |  |                              |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><u>BURIAL</u>   |  | 23b. DATE<br><u>12-16-59</u>  |   | 23c. NAME OF CEMETERY OR CREMATORY<br><u>SANDHILL</u>   |   |  |   | 23d. LOCATION (City, town, or county) (State)<br><u>NEW MADRID MO</u>      |  |  |  |                              |  |
| 24. FUNERAL DIRECTOR<br><u>Ed Hedgepeth</u> ADDRESS <u>New Madrid</u>  |  |   |   | 25. DATE RECD. BY LOCAL REG.<br><u>12-21-59</u>   |   |  |   | 26. REGISTRAR'S SIGNATURE<br><u>Marjorie Hunter</u>                        |  |  |  |                              |  |

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

(Licensed Embalmer's Statement on Reverse Side)

**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by  
or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_  
working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed *[Handwritten Signature]*

Licensed Embalmer No. 3823

P. O. Address New York

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.