

FEDERAL DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-037656

FILLED NOV 1 1960

Registration District No. 47 Primary Registration District No. 3008 Registrar's No. 297

STATE FILE NUMBER

DEED

1. PLACE OF DEATH a. COUNTY <u>Callaway</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>Pemiscot</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Fulton</u>		Length of stay in 1b <u>6 years</u>	c. CITY OR TOWN <u>Steele</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>State Hospital #1</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>R.F.D.# 1</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <u>Thomas</u> Middle <u>Jefferson</u> Last <u>Hickerson</u>			4. DATE OF DEATH Month <u>October</u> Day <u>22</u> Year <u>1960</u>		
5. SEX <u>male</u>	6. COLOR OR RACE <u>negro</u>	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>7/4/1921</u>	9. AGE (last birthday) <u>39 ?</u>	IF UNDER 1 YEAR Months <u>3</u> Days <u>18</u> Hours <u></u> Min. <u></u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>farm worker</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>none</u>	11. BIRTHPLACE (City and state or country) <u>Woodland Mississippi</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>
13a. FATHER'S NAME <u>Monroe Hickerson</u>		13b. MOTHER'S MAIDEN NAME <u>Anna Woffard</u>		14. NAME OF HUSBAND OR WIFE <u></u>	

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>unknown</u>	16. SOCIAL SECURITY NO. <u>499-42-0274</u>	17. INFORMANT <u>St. Hospital #1 records Fulton, Mo</u>
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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>Lungs - lobar pneumonia, bilateral</u>		INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b)	
	DUE TO (c)	

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Mental Deficiency</u>	PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
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19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input 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 <u></u> a.m. <u></u> p.m. <u></u>	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 <u>State Hosp #1</u>	COUNTY <u>Fulton</u>	STATE <u>Mo</u>
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21. I attended the deceased from Sept. 1960 to Oct. 22, 1960 and last saw ^{her}him alive on Oct. 22, 1960
Death occurred at 3.00 p.m. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <u>W.B. Jackson, M.D.</u> (Degree or title)	22b. ADDRESS <u>107-A Court St.</u>	22c. DATE SIGNED <u>10/22/60</u> (State)
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>Oct. 25, 1960</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Oak Grove Cemetery</u>	23d. LOCATION (City, town, or county) <u>Holland Mo</u>
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24. FUNERAL DIRECTOR <u>Wallace Funeral Home, Fulton Mo</u>	25. DATE RECD. BY LOCAL REG. <u>Oct. 22 - 1960</u>	26. REGISTRAR'S SIGNATURE <u>Maretta Lawrence</u>
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(Licensed Embalmer's Statement on Reverse Side)

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

NOV 2 1960

Job:

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 Denzil O. Browning

Licensed Embalmer No. 2728

P. O. Address Fulton, Md

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.