

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

31187

State File No.

Registration District No. 104

Primary Registration District No. 3008

Registrar's No. 224

1. PLACE OF DEATH:

(a) County Callaway
(b) City or town Fulton Co. Mo.
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: State Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 15 days
(Specify whether
In this community
years, months or days)

3. (a) PRINT FULL NAME Sam Hickcox3. (b) If veteran,
name war3. (c) Social Security
No. D.K.

4. Sex Male 5. Color or race Black 6. (a) Single, widowed, married,
divorced Married
6. (b) Name of husband or wife Mollie 6. (c) Age of husband or wife if
alive D.K. years
7. Birth date of deceased D.K.
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
76 hr. min.

9. Birthplace D.K. 9
(City, town, or county) (State or foreign country)10. Usual occupation Laborer

11. Industry or business

MOTHER FATHER { 12. Name D.K. 9
13. Birthplace (City, town, or county) (State or foreign country)14. Maiden name D.K.
15. Birthplace (City, town, or county) (State or foreign country)16. (a) Informant Hospital records
(b) Address Fulton, Mo.17. (a) Burial (b) Date thereof 8/23/41
(Burial, cremation, or removal) (Month) (Day) (Year)18. (a) Signature of funeral director Callaway & Grubbs
(b) Address California Mo19. (a) 8-21-41 (b) R. N. Chew
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Monitoy 14
(c) City or town California 1
(If outside city or town limits, write "RURAL") 2
(d) Street No. LA
(If rural, give location)
(e) If foreign born, how long in U. S. A. ? years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month August day twenty-first
year 1941 hour 5⁴⁵ minute 45 P.M.21. I hereby certify that I attended the deceased from August
eleventh, 1941, to Aug. 21st, 1941;
that I last saw him alive on August 21st, 1941;
and that death occurred on the date and hour stated above.Immediate cause of death Terminal
bronco-pneumonia Duration 7 daysDue to Cerebral hemorrhage
chronic myocarditis
Due to HypertensionOther conditions
(Include pregnancy within 3 months of death)Major findings:
Of operations 101
Of autopsy

PHYSICIAN

Underline
the cause to
which death
should be
charged sta-
tistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify)
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place?

While at work? (Specify type of place) Means of injury

23. Signature State Hospital (M. D. or other) 1
Address State Hospital Date signed 8/21/41

0012 11211

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.....

....., Registered Apprentice No.....
working under my personal supervision.

Signed.....

Licensed Embalmer No. 3754

P. O. Address: California

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 this body is not embalmed, fact should be so stated above.