

FILED SEP 29 1948

Primary Registration District No. 51826

Registrar's No. 78

1. PLACE OF DEATH:

(a) County Cape Girardeau

(b) City or town Rural Shannon Mo  
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: Jackson Mo R#1  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution.....  
(Specify whether

In this community.....  
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Cape Girardeau

(c) City or town Rural Shannon Mo  
(If outside city or town limits, write "RURAL")

(d) Street No. Jackson Mo R#1  
(If rural, give location)

(e) Citizen of foreign country? no (Yes or No)

If yes, name country.....

3. (a) PRINT FULL NAME CHARLES WESLEY TRICKEY

3. (b) If veteran, name war.....

3. (c) Social Security No. ....

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept day 13  
year 1948 hour 9 minute 40 P.M.

21. I hereby certify that I attended the deceased from Sept 12 1948  
that I last saw him alive on September 12 1948  
and that death occurred on the date and hour stated above. Duration

Immediate cause of death Cerebral Hemorrhage

4. Sex M 5. Color or race w 6. (a) Single, widowed, married, divorced married

(b) Name of husband or wife Emma Lida Trickey 6. (c) Age of husband or wife if alive 76 years

7. Birth date of deceased 29 1869  
(Month) (Day) (Year)

Due to High Blood Pressure

Due to.....

Other conditions (include pregnancy within 3 months of death).....

Major findings: gdn

Of operations.....

Of autopsy.....

PHYSICIAN  
Underline the cause of which death should be charged statistically.

8. AGE: Years 78 Months 10 Days 15 If less than one day  
hr. min.

9. Birthplace New Wellmo (City, town, or county) (State or foreign country) 0

10. Usual occupation Farmer

MOTHER FATHER

11. Industry or business.....

12. Name John A. Trickey D

13. Birthplace New Wellmo (City, town, or county) (State or foreign country)

14. Maiden name Not Known

15. Birthplace 9 (City, town, or county) (State or foreign country)

16. (a) Informant Wm Trickey

(b) Address Jackson mo R 1

17. (a) Burial (b) Date thereof 9-16-48  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Gair Wexp. Cemetery

18. (a) Signature of funeral director McComb

(b) Address Jackson mo

19. (a) 9-18-48 (b) D.G. Sibus  
(Date received by registrar) (Registrar's signature) 43

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?.....  
(Specify type of place)

While at work? (e) Means of injury D

23. Signature A D Blaylock (M. D. number M.D.)  
Address Oak Ridge Mo Date signed 9-19-48

WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

RECEIVED

Health Officer No. 4

File Number 948-1

Date Filed 9-28-4

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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 \_\_\_\_\_

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

Signed Chas. K. Allen

Licensed Embalmer No. 40535

P. O. Address Jackson

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.