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7-39
K37823

FILED JUN 5 1944
Registration District No.

Primary Registration District No. 5183

1. PLACE OF DEATH:

(a) County Cape Girardeau
 (b) City or town Rural (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution: Jackson Mo R.F. #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 (If outside city or town limits, write "RURAL")
 (d) Street No. Jackson Mo R.F. #1 (If rural, give location)
 (e) Citizen of foreign country? no (Yes or No)
 If yes, name country _____

3. (a) PRINT FULL NAME Ohvie Trickey
 (b) If veteran, name war _____ (c) Social Security No. none

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 28 year 1944 hour 6 minute 30 P.M.
 21. I hereby certify that I attended the deceased from now 1944 to May 1944
 that I last saw him alive on May 20 1944 and that death occurred on the date and hour stated above.

4. Sex M 5. Color or race w 6. (a) Single, widowed, married, divorced married
 (b) Name of husband or wife Josephine Catherine Trickey (c) Age of husband or wife if alive 74 years
 7. Birth date of deceased: April 10 1869 (Month) (Day) (Year)

Immediate cause of death Coronary Thrombosis Duration 4 hrs

8. AGE: Years 75 Months 1 Days 18 If less than one day _____ hr. _____ min.
 9. Birthplace Jackson Mo R.F. #1 (City, town, or county) - (State or foreign country) 0

Due to Coronary heart disease 2 yr
 Due to Coronary sclerosis? 2 yr
 Other conditions _____ (Include pregnancy within 3 months of death)

10. Usual occupation Farmer
 11. Industry or business _____
 12. Name Thomas Trickey
 13. Birthplace Not Known (City, town, or county) (State or foreign country) 9
 14. Maiden name Elizabeth Brummer
 15. Birthplace Not Known (City, town, or county) (State or foreign country) 9

Major findings: Of operations _____ Of autopsy _____
 PHYSICIAN [Signature]
 Underline the cause to which death should be charged statistically.

16. (a) Informant Mrs Ohvie Trickey
 (b) Address Jackson Mo R.F. #1
 17. (a) Burial (b) Date thereof May 30 1944 (Burial, cremation, or removal) (Month) (Day) (Year)
 (c) Place: burial or cremation Indian Wells McComb's Church
 18. (a) Signature of funeral director [Signature]
 (b) Address Jackson Mo
 19. (a) 5/20 44 (b) J. C. Keates (Date received local registrar) (Registrar's signature)

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) (c) Means of injury _____
 23. Signature T. E. Ruff (M. D. or other) MD
 Address Jackson Date signed 5.29.44

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

MOTHER FATHER

11110

RECEIVED

District Health Officer No. 4

District File Number 644-3915

Date Filed 6-7-44

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 B. A. Meyer

Licensed Embalmer No. 3057

P. O. Address Jackson M.

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.