WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

PLACE OF DEATH

County Monteau

Township Harrison

or Village ~~High Point~~

or City _____ (No. _____ St.: _____ Ward)

Registration District No. 276

Primary Registration District [redacted]73

File No. 20837

Registered No. 9

[If death occurred in a hospital or institution, give its NAME instead of street and number]

FULL NAME Sam Harrison Hickcox

PERSONAL AND STATISTICAL PARTICULARS

SEX	COLOR OR RACE	SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word)
Male	Colored	Single

DATE OF BIRTH: March (Month) 4th (Day) 1889 (Year)

AGE: 21 yrs. 4 mos. 16 ds. If LESS than 1 day, ____ hrs. or ____ min.?

OCCUPATION
(a) Trade, profession, or particular kind of work: Waiter

(b) General nature of industry, business, or establishment in which employed (or employer): General Hotel

BIRTHPLACE (City or town, State or foreign country): Monteau Co Mo

PARENTS

NAME OF FATHER: Joseph Hickcox

BIRTHPLACE OF FATHER (City or town, State or foreign country): High Point

MAIDEN NAME OF MOTHER: Hester A. Hickman

BIRTHPLACE OF MOTHER (City or town, State or foreign country): Near Taylors

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant): Hester Hickcox

(ADDRESS) High Point

Filed 7/14/10 1910 C D Osborne, REGISTRAR

3 MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH: 7 (Month) 19 (Day) 1910 (Year)

I HEREBY CERTIFY, that I attended deceased from On 7-19, 1910, to _____, 191__, that I last saw h~~im~~ alive on 7-19, 1910, and that death occurred, on the date stated above, at 4 P m.

The CAUSE OF DEATH* was as follows:

Tuberculosis

23A

11A (Duration) ____ yrs. 6 mos. ____ ds.

Contributory (Secondary) Cold + Grippe

(Duration) ____ yrs. ____ mos. ____ ds.

(Signed) J. L. Gilleland M. D.

7-26th 1910 (Address) Oleon Mo.

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury: and (2) whether Accidental, Suicidal, or Homicidal.

LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death ____ yrs. ____ mos. ____ ds. In the State ____ yrs. ____ mos. ____ ds.

Where was disease contracted if not at place of death?

Former or usual residence

PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL: 7-20 1910

UNDERTAKER: Jno E Longan

ADDRESS: Ware

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

PLACE OF DEATH

County.....

Township.....
or
Village.....
or
City.....

District No..... File No.....

Registration District No..... Registered No.....

(No.....St.;.....Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number]

FULL NAME.....

PERSONAL AND STATISTICAL PARTICULARS

SEX	COLOR OR RACE	SINGLE MARRIED WIDOWED OR DIVORCED (*Write* the word)

DATE OF BIRTH

....., 1.....
(Month) (Day) (Year)

AGE

.....yrs.....mos.....ds.

If LESS than 1 day,.....hrs. or.....min.?

OCCUPATION
(a) Trade, profession, or particular kind of work .....

(b) General nature of industry, business, or establishment in which employed (or employer) .....

BIRTHPLACE
(City or town, State or foreign country)

PARENTS

NAME OF FATHER

BIRTHPLACE OF FATHER
(City or town, State or foreign country)

MAIDEN NAME OF MOTHER

BIRTHPLACE OF MOTHER
(City or town, State or foreign country)

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant).....

(ADDRESS).....

Filed ....., 191...., ...
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH

....., 191....
(Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from ....., 191...., to....., 191....,

that I last saw h.....alive on....., 191....,

and that death occurred, on the date stated above, at.....m.

The CAUSE OF DEATH* was as follows:

.....

.....

.....

.....(Duration).....yrs.....mos.....ds.

Contributory.....
(SECONDARY)

.....(Duration).....yrs.....mos.....ds.

(Signed).....M. D.

....., 191.... (Address).....

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury: and (2) whether Accidental, Suicidal, or Homicidal.

LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted if not at place of death? .....

Former or usual residence.....

PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
	....., 191....
UNDERTAKER	**ADDRESS**

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

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