

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

Do not use this space.

11035-  
1609 11085

1. PLACE OF DEATH

County Jackson Registration District No. 399  
Township Kaw Primary Registration District No. 1002  
City Kansas City (No. 514 West 25th)

File No. ....  
Registered No. ....  
St. .... Ward)

2. FULL NAME Joel Hicks

(a) Residence. No. 514 West 25th Kansas City Ward. ....  
(Usual place of abode) (If nonresident give city or town and State)  
Length of residence in city or town where death occurred yrs. mos. da. How long in U.S., if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Married

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF

Emma Hicks

6. DATE OF BIRTH (MONTH, DAY AND YEAR) April 21, 1844

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.  
84 11 5

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Laborer

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

(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN)

(STATE OR COUNTRY) Illinois

10. NAME OF FATHER Jesse Hicks

11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) Tennessee

12. MAIDEN NAME OF MOTHER Howard

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) Tennessee

14. INFORMANT Emma Hicks  
(Address) 514 West 25th

15. FILED 4/3 1929 M. M. Crave REGISTRAR

3 MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 3/26 1929

17. I HEREBY CERTIFY, That I attended deceased from Deputy Coroner 1929, to 1929, and that

that I last saw h..... alive on....., 19....., and that death occurred, on the date stated above, at.....

THE CAUSE OF DEATH\* WAS AS FOLLOWS:

Septicemia

CONTRIBUTORY (SECONDARY) Infected Gangrene of foot (duration) yrs. mos. da.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH.....

19. DID AN OPERATION PRECEDE DEATH? no DATE OF.....

20. WAS THERE AN AUTOPSY? no

21. WHAT TEST CONFIRMED DIAGNOSIS? History of Amputation

(Signed) Stanley M. Ball, M. D.

3/26 1929 (Address) Deputy Coroner

\*State the DISEASE CAUSING DEATH, or if deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL

Hazel Hill DATE OF BURIAL 4/2/29 19

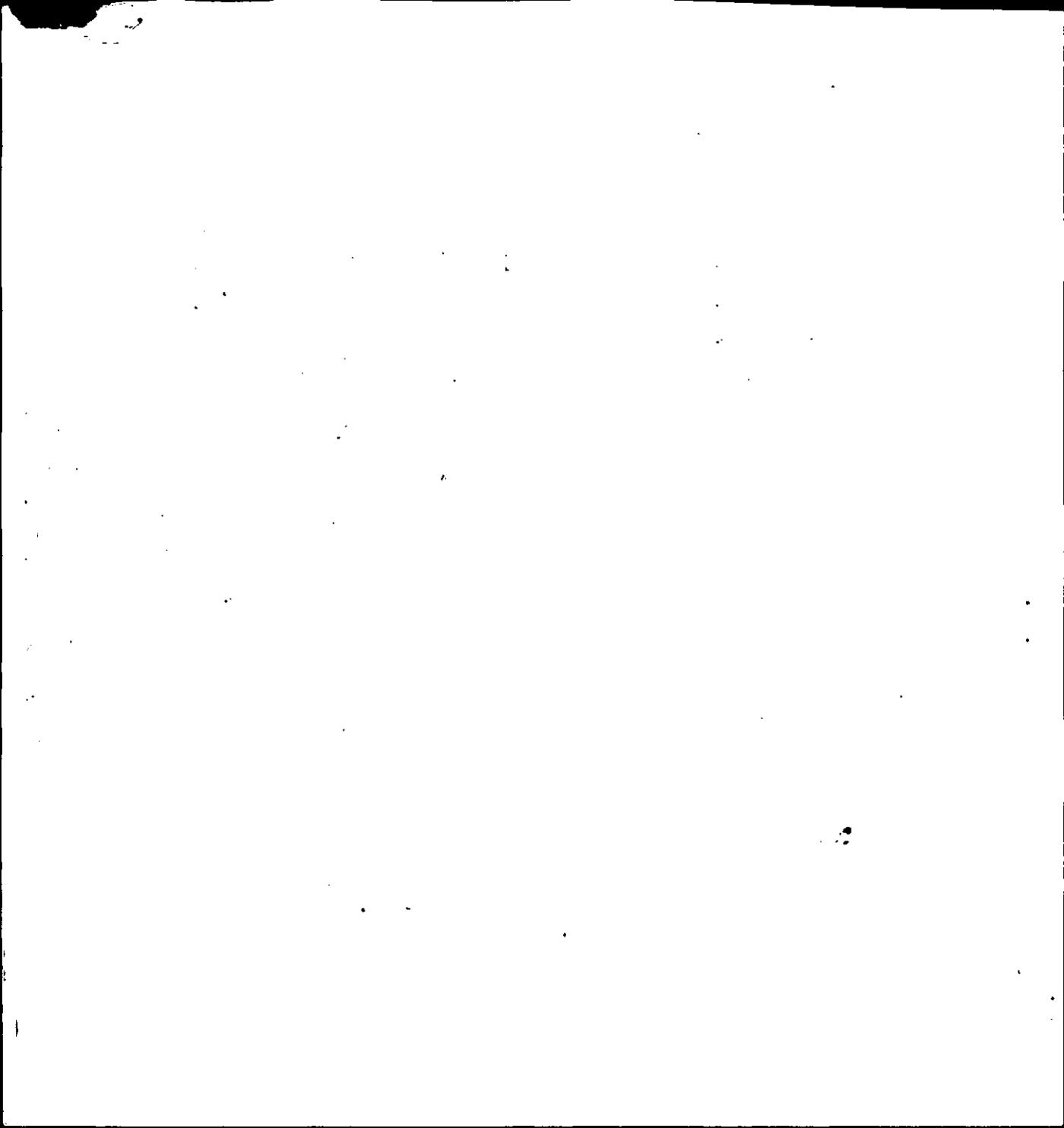
20. UNDERTAKER

R. V. LINDSEY & SONS, Inc

ADDRESS

3811 Broadway

K.C. 120



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

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

**1. PLACE OF DEATH**

County..... Registration District No..... File No.....  
Towship..... Primary Registration District No..... Registered No. 1609  
City..... (No. 514) W 25<sup>th</sup> St..... St..... Ward.....

**2. FULL NAME**

Joel Hicks

(a) Residence No..... St.,..... Ward.....  
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

**PERSONAL AND STATISTICAL PARTICULARS**

3. SEX..... 4. COLOR OR RACE..... 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word).....

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF.....

6. DATE OF BIRTH (MONTH, DAY AND YEAR).....

7. AGE YEARS MONTHS DAYS If LESS than 1 day, ..... hrs. or ..... min.

**8. OCCUPATION OF DECEASED**

(a) Trade, profession, or particular kind of work.....  
(b) General nature of industry, business, or establishment in which employed (or employer).....  
(c) Name of employer.....

9. BIRTHPLACE (CITY OR TOWN)..... (STATE OR COUNTRY).....

10. NAME OF FATHER.....

11. BIRTHPLACE OF FATHER (CITY OR TOWN)..... (STATE OR COUNTRY).....

12. MAIDEN NAME OF MOTHER.....

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)..... (STATE OR COUNTRY).....

14. INFORMANT (Address).....

15. FILED 4/3 1929 M. M. Browe REGISTRAR  
Asst

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) 3-26 1929

17. I HEREBY CERTIFY, That I attended deceased from....., 19....., that I last saw h..... alive on....., 19....., and that death occurred, on the date stated above, at..... m.

THE CAUSE OF DEATH WAS AS FOLLOWS:

Septicemia  
..... (duration) yrs. mos. ds.

CONTRIBUTORY (SECONDARY) Infected, Bacteremia in foot, septic  
..... (duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED Unknown - No details  
IF NOT AT PLACE OF DEATH.....

DID AN OPERATION PRECEDE DEATH? no DATE OF.....

19. WAS THERE AN AUTOPSY? no DATE OF.....

WHAT TEST CONFIRMED DIAGNOSIS? hematology

(Signed) Amey M. Hall, M. D.

, 19 (Address) Deputy coroner

\*State the DISEASE CAUSING DEATH, or in death from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, OF HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL DATE OF BURIAL

20. UNDERTAKER ADDRESS

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW

**SUPPLEMENTARY**

5-11085

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