16-46

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

Do not use this space.

26538

File No. 3281
Registered No.

1. PLACE OF DEATH
County Jackson Registration District No. 399
Township Kaw Primary Registration District No. 1002
City Kansas City (No. St. Luke's Hospital St. Ward)

2. FULL NAME Jane Eliza Hickman
(a) Residence No. 19 Linwood Terrace 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.

SEP 26 1933

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 OCUPATION is very important.

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

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
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: Chas Hickman

6. DATE OF BIRTH (MONTH, DAY, AND YEAR): 8-24-1886

7. AGE: Years 46 Months 11 Days 12 If LESS than 1 day, ...hrs. or ....min.

OCCUPATION
8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc.: Stenographer
9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.:
10. Date deceased last worked at this occupation (month and year):
11. Total time (years) spent in this occupation:

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY): Kansas City Kansas

FATHER
13. NAME: Edward T. Jones
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY): Wales British

MOTHER
15. MAIDEN NAME: Jane Allis
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY): Wales. British

17. INFORMANT (ADDRESS): Chas Hickman, 19 Linwood Terrace

18. BURIAL, CREMATION, OR REMOVAL
PLACE: Forest Hill DATE: 8/17 1933

19. UNDERTAKER (ADDRESS): O. V. MAST FUNERAL ... 3146 Main St.

20. FILED: 8/17 1933 M. M. Crowe, Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR): 8-15- 1933

22. I HEREBY CERTIFY, That I attended deceased from 8-14- 1933, to 8-15- 1933
I last saw her alive on 8-15 1933. Death is said to have occurred on the date stated above, at 2:50 p.m.
The principal cause of death and related causes of importance were as follows:

Cerebral hemorrhage — Date of onset 8-14-33

Other contributory causes of importance: Essential hypertension ?

Name of operation ..... Date of .....
What test confirmed diagnosis? ..... Was there an autopsy? Yes

23. If death was due to external causes (violence), fill in also the following:
Accident, suicide, or homicide? ..... Date of injury ....., 19....
Where did injury occur? .....
(Specify city or town, county, and State)
Specify whether injury occurred in industry, in home, or in public place.
Manner of injury .....
Nature of injury .....

24. Was disease or injury in any way related to occupation of deceased? No
If so, specify .....
(Signed) N. A. Bertsche, M. D.
(Address) 818 Medical Arts

office hours 2 to 5 pm

Dr H.A. Breyfogle
Medical Arx Bldg

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