

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

13874
 Do not use this space.

DEC'D MAY 10 1939

1. PLACE OF DEATH

(a) County Jackson Registration District No. 399
 (b) Township Man Primary Registration District No. 1002
 (c) City Kansas City (d) Street No. 504 Benton St.
 (If death occurred in Hospital or Institution, write its name instead of street and number)
 (e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

Registered No. **1628**

2. PRINT FULL NAME William J. Hicks

(a) Residence, No. North R.C. mo. St. (If nonresident, give city or town and State)
 (Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

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

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Mrs. Nancy Jane Hicks

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) June 20-1843

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
85 9 26

OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. None
 9. Industry or business in which work was done, as 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) Warsaw Mo.

FATHER 13. NAME James Hicks

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) mo.

MOTHER 15. MAIDEN NAME Martha Morgan

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) mo.

17. INFORMANT (NAME) Mrs. O. W. Leonard
 (ADDRESS) North R.C. mo RFD

18. BURIAL, CREMATION, OR REMOVAL PLACE Memorial Park DATE 4-18, 1939

19. FUNERAL DIRECTOR (NAME) Mr. C. R. Foster
 (ADDRESS) 918 Brooklyn R.C. mo
Apr 18 39 Dr. M. Crowe

20. FILED Apr 18 39 Dr. M. Crowe
 Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) April 16 1939

22. I HEREBY CERTIFY, That I attended deceased from Apr 14, 1939, to Apr 16, 1939
 I last saw him alive on Apr 15, 1939 Death is said to have occurred on the date stated above, at 9:00 a.m.
 The principal cause of death and related causes of importance were as follows:

Chronic myocarditis
930
 Date of onset

Other contributory causes of importance:
Stility

Name of operation none Date of none
 What test confirmed diagnosis? Physical Exam. Was there an autopsy? no.

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) Dr. M. Crowe, M. D.
 (Address) 385 2nd St. Kansas City, Mo.

1303
111
Kills 6/2/17
219755
The old man pg

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.....

Licensed Embalmer No.....

P. O. Address.....

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, above space should be left blank.