

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.

Registration District No. 399

Primary Registration District No. 1002

1. PLACE OF DEATH:

(a) County Jackson  
 (b) City or town Kansas City  
 (If outside city or town limits, write "RURAL" and name of township)  
 (c) Name of hospital or institution: North East Hospital  
 (If not in hospital or institution, write street number or location)  
 (d) Length of stay: In hospital or institution 4 days  
 (Specify whether years, months or days)  
 In this community 20 yrs.

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Jackson  
 (c) City or town Kansas City  
 (If outside city or town limits, write "RURAL")  
 (d) Street No. 1015 - E-10th  
 (If rural, give location)  
 (e) If foreign born, how long in U. S. A.? 56 years.

MEDICAL CERTIFICATION

3. (a) PRINT FULL NAME Lee Roy Hicks 2nd  
 3. (b) If veteran, Private Co. J. 20-Inf. Social Security  
 name war World War  No. none

20. DATE OF DEATH: Month August day 29th  
 year 39 hour 2 minute 45 P.M.  
 21. I hereby certify that I attended the deceased from Aug 25th  
1939, to Aug 29th, 1939.

4. Sex Male 5. Color or race White  
 6. (a) Single, widowed, married, divorced Married  
 6. (b) Name of husband or wife May Hicks  
 6. (c) Age of husband, or wife if alive 48 years  
 7. Birth date of deceased Nov 5 1892  
 (Month) (Day) (Year)

that I last saw him alive on Aug 29th and that death occurred on the date and hour stated above.  
 Immediate cause of death completely decomposed heart, with dependent edema and hypertensive pneumonia  
 Due to Syphilis, causing aortic and mitral regurgitation, with liver cirrhosis  
 Due to degenerated chlorides and hemorrhage per dissepidesis

8. AGE: Years Months Days If less than one day  
56 9 24 hr. min.

Duration  
 Other conditions (include pregnancy within 3 months of death) 34

9. Birthplace Iowa  
 (City, town, or county) (State or foreign country)

10. Usual occupation Barber

11. Industry or business 5

12. Name Jack Hicks

13. Birthplace Ireland  
 (City, town, or county) (State or foreign country)

14. Maiden name No Record

15. Birthplace No Record  
 (City, town, or county) (State or foreign country)

16. (a) Informant's own signature May Hicks  
 (b) Address 1015 East 10th, Str., K.C. Mo.

17. (a) Burial (b) Date thereof Shin-8-31-39  
 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Burial Ottumwa, Iowa.

18. (a) Signature of funeral director Mrs. C. L. Forster  
 (b) Address 918 Brooklyn Avenue, K.C. Mo.

19. (a) 8/30/39 (b) M. M. Crowe  
 (Date received local registrar) (Registrar's signature)

Major findings: Of operations  
 Of autopsy

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? 5 (Specify type of place)  
 (e) Means of injury  
 23. Signature J. P. M. Larson (M. D. or other)  
 Address 615 - 630 Lee Bldg. Date signed 8-29-39

PHYSICIAN  
 Underline the cause to which death should be charged statistically.

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**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 *Denzil C. Browning*

Licensed Embalmer No. *2724*

P. O. Address *918 Brooklyn St. C. N.*

**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.**