

Registration District No. 399

Primary Registration District No. 1002

1. PLACE OF DEATH: **NOV 14 1939**  
(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: 5712 Virginia  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution all her life (Specify whether years, months or days)

3. (a) PRINT FULL NAME Mrs. Louisa Dicke 200  
3. (b) If veteran, name war None  
3. (c) Social Security No. None

4. Sex Female 5. Color or race Wh  
6. (a) Single, widowed, married, divorced Widowed  
6. (b) Name of husband or wife Henry Dicke  
6. (c) Age of husband or wife if alive 24 - 1853 years  
7. Birth date of deceased (Month) Oct (Day) 24 (Year) 1853

8. AGE: Years 86 Months 0 Days 3 If less than one day hr. min.

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

10. Usual occupation At Home

11. Industry or business  
12. Name No Record  
13. Birthplace " (City, town, or county) (State or foreign country)  
14. Maiden name No Record  
15. Birthplace " (City, town, or county) (State or foreign country)

16. (a) Informant's own signature Catherine White  
(b) Address 5712 Virginia K.C. Mo.

17. (a) Removal (b) Date thereof Oct 30 - 1939  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Wagstaff Kansas  
18. (a) Signature of funeral director John W. Wagner  
(b) Address Kansas City, Mo.

19. (a) 10/30/39 (b) M. M. Crowe  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:  
(a) State Missouri (b) County Jackson  
(c) City or town Kansas City  
(If outside city or town limits, write "RURAL")  
(d) Street No. 5712 Virginia (If rural, give location)  
(e) If foreign born, how long in U. S. A. \_\_\_\_\_ years.

MEDICAL CERTIFICATION  
20. DATE OF DEATH: Month Oct. day 27  
year 1939 hour 8 minute 25 A.M.  
21. I hereby certify that I attended the deceased from Oct 1 - 39  
\_\_\_\_\_, 19\_\_\_\_, to Oct 27, 1939;  
that I last saw her alive on Oct. 26, 1939;  
and that death occurred on the date and hour stated above.

Immediate cause of death  
Arterio-Sclerosis  
Cardiac degeneration  
Old age  
Due to 932  
Due to \_\_\_\_\_  
Other conditions (include pregnancy within 3 months of death) \_\_\_\_\_

Major findings: Of operations \_\_\_\_\_  
Of autopsy \_\_\_\_\_  
PHYSICIAN \_\_\_\_\_  
Underline (the cause to which death should be charged statistically).

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? \_\_\_\_\_ (Specify type of place) (d) Means of injury \_\_\_\_\_  
23. Signature [Signature] (M. D. or other) \_\_\_\_\_  
Address 802 + 1/2 1st Date signed 10/27/39

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

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1-119511

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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**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 PK Hauschild

Licensed Embalmer No. 4062

P. O. Address B. C. M. D.

**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.**