S. No. 2
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WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED MAY 15 1940

Registration District No. 399

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

Primary Registration District No. 1002

Dr. Swarens.

State File No. 13776

Registrar's No. 1488

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: Vineyard Park Hospital. (If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution Six days (Specify whether

In this community Life years, months or days)

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. 2730 Cypress st. (If rural, give location)

(e) If foreign born, how long in U. S. A.? ..... years.

3. (a) PRINT FULL NAME James Paul Hickey

James Paul Hickey 2nd

3. (b) If veteran, name war None

3. (c) Social Security No. None

4. Sex Male

5. Color or Race White

6. (a) Single, widowed, married, Married

6. (b) Name of husband or wife Beulah Hickey

6. (c) Age of husband or wife if alive 30 years

7. Birth date of deceased January (Month) 12 (Day) 1908 (Year)

8. AGE:

Years	Months	Days	If less than one day
32	2	22	hr. min.

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

10. Usual occupation Insurance salesman

11. Industry or business

FATHER
12. Name James Barton Hickey
13. Birthplace Warrensburg (City, town, or county) Missouri (State or foreign country)

MOTHER
14. Maiden name Carrie Tugner
15. Birthplace Springfield (City, town, or county) Illinois (State or foreign country)

16. (a) Informant Mrs Carrie B Hickey

(b) Address 2730 Cypress Kansas City Mo

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof April 6, 1940 (Month) (Day) (Year)

(c) Place: burial or cremation Elmwood Cemetery

18. (a) Signature of funeral director Leland H Francis

(b) Address Parkville Mo

19. (a) April 5, 1940 (Date received local registrar) (b) M. M. Crowe (Registrar's signature)

MEDICAL CERTIFICATION

20. **DATE OF DEATH:** Month April day 4th year 1940 hour 7 minute 30 A. M.

21. I hereby certify that I attended the deceased from March 7, 1940, to April 4, 1940 that I last saw him alive on April 3rd 9 P.M. 1940 and that death occurred on the date and hour stated above.

Immediate cause of death Bronchial Pneumonia 107a

Duration 3 days

Due to Morphine Addict

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? (Specify type of place)

While at work? (e) Means of injury

23. Signature J. F. Swarens (M. D. or other)

Address 2816 East 6th St Date signed 4/6/40

(Licensed Embalmer's Statement on Reverse Side)

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 Yes

....., Registered Apprentice No.....

working under my personal supervision.

Signed Leland H Francis

Licensed Embalmer No. 3451

P. O. Address Parkville Mo

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply wi the above constitutes grounds for revocation of license.)

If this body is not embalmed, above space should be left blank.