

No. 2  
-10-397  
17-39  
X21492

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

17643

ED JUN 17 1940

State File No. \_\_\_\_\_

Registration District No. 399

Primary Registration District No. 1002

Registrar's No. 2170

**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:  
General Hospital  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution \_\_\_\_\_  
(Specify whether)

In this community All her life  
years, months or days

3. (a) PRINT FULL NAME MRS ETHEL I. HICKERSON

3. (b) If veteran, name war \_\_\_\_\_

3. (c) Social Security No. None

4. Sex Female

5. Color or race White

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

6. (b) Name of husband or wife Samuel Leroy Hickerson

6. (c) Age of husband or wife if alive 35 years

7. Birth date of deceased June 5 1909  
(Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
30	11	19	hr. min.

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

10. Usual occupation At Home

11. Industry or business \_\_\_\_\_

MOTHER FATHER {

12. Name Floyd Corliss

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

14. Maiden name Oshel

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

16. (a) Informant Roy Hickerson

(b) Address 8135 Agnes

17. (a) burial (b) Date thereof 5/27/40  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Memorial Park

18. (a) Signature of funeral director R. V. Lindsey & Sons

(b) Address 3811 Broadway

19. (a) May 27, 1940 (b) M. M. Browne  
(Date received local registrar) (Registrar's signature)

**2. USUAL RESIDENCE OF DECEASED:**

(a) State Missouri (b) County Washington

(c) City or town Rural Washington Township  
(If outside city or town limits, write "RURAL")

(d) Street No. 8135 Agnes  
(If rural, give location)

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 5 day 24 year 1940  
hour \_\_\_\_\_ minut 6:15 P. M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_ to \_\_\_\_\_, 19\_\_\_\_.

that I first saw him alive \_\_\_\_\_ to \_\_\_\_\_, 19\_\_\_\_.

and that death occurred on the date and hour stated above.

Immediate cause of death \_\_\_\_\_

10-20-30 burns of face,  
Chest, back, abdomen, arms  
and legs

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions \_\_\_\_\_  
(Include pregnancy within 3 months of death)

PHYSICIAN \_\_\_\_\_

Major findings: \_\_\_\_\_

Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

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) Accident

(b) Date of occurrence 5-8-40

(c) Where did injury occur? K.C. Mo  
(City or town) (County) (State)

(d) Did injury occur in or about home \_\_\_\_\_ on farm \_\_\_\_\_ in industrial place \_\_\_\_\_ in public place?  
Explosion of gas in place

While at work? reaffirming place (Specify place) \_\_\_\_\_

(e) Means of injury \_\_\_\_\_

23. Signature M. M. Browne (M. D. or other) \_\_\_\_\_

Address K.C. Mo. Date signed \_\_\_\_\_

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

**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.....

.....  
working under my personal supervision.

Registered Apprentice No. ....

Signed.....

Licensed Embalmer No. 3738

P. O. Address..... Kepler

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

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