

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **27541**
3174

Registration District No. **399**

Primary Registration District No. **1002**

Registrar's No.

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:
3019 Euclid
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution X
(Specify whether)
In this community all her life
years, months or days

3. (a) PRINT FULL NAME Mrs. Cornelia Hickman Leverage

8. (b) If veteran, name war NO.

3. (c) Social Security No. NO.

4. Sex Female

5. Color or race White

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

6. (b) Name of husband or wife Unknown

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

7. Birth date of deceased: December 5, 1865
(Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
<u>74</u>	<u>8</u>	<u>2</u>	hr. min.

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

10. Usual occupation at home

11. Industry or business X

MOTHER FATHER { 12. Name John Lewis Hickman

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

14. Maiden name Ella Walker

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

16. (a) Informant Miss Mary Hickman

(b) Address 3019 Euclid, Kansas City, Mo.

17. (a) Burial
(Burial, cremation, or removal)

(b) Date thereof 8-9-40
(Month) (Day) (Year)

(c) Place: burial or cremation Forest Hill Cemetery

18. (a) Signature of funeral director Stine & McClure

(b) Address 3235 Gillham Plaza, K. C., Mo.

19. (a) Aug. 9, 1940
(Date received local registrar)

(b) M. M. Craue
(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. 3019 Euclid
(If rural, give location)

(e) If foreign born, how long in U. S. A.? NO. years

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month August day 7th,
year 1940 hour 4:00 minute P. M.

21. I hereby certify that I attended the deceased from 19 to 19
that last saw him alive on 19
and that death occurred on the date and hour stated above.

Immediate cause of death

Septicemia
Septicemia of left leg
thrombosis of left femoral artery

Duration

Major findings:
Of operations 99a

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)

(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 Yes
(Specify type of place)

23. Signature M. M. Craue (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.....

....., Registered Apprentice No.....
working under my personal supervision.

Signed J B Waters
Licensed Embalmer No. 3992
P. O. Address RC Mo

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.