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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

JAN 8 1940

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 41654

Registration District No. 399 Primary Registration District No. 1002 Registrar's No. 5047

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

1. PLACE OF DEATH:

(a) County Jackson 1

(b) City or town Kansas City
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: K.C. General Hospital-K.C., Mo.
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 4 1/2 DAYS (Specify whether
In this community 4 1/2 DAYS years, months or days)

2. USUAL RESIDENCE OF DECEASED: 0

(a) State Missouri (b) County Jackson

(c) City or town Kansas City
(If outside city or town limits, write "RURAL")

(d) Street No. 804 Woodland Room 415
(If rural, give location)

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

3. (a) PRINT FULL NAME Infant Hickman ~~[illegible]~~ INFANT HICKMAN

3. (b) If veteran, name war ..... 3. (c) Social Security No. .....

4. Sex MALE 5. Color or race W 6. (a) Single, widowed, married, divorced Single

6. (b) Name of husband or wife ..... 6. (c) Age of husband or wife if alive — years

7. Birth date of deceased 10 — 24 — 40 (Month) (Day) (Year)

8. AGE: Years | Months | Days 4 1/2 | If less than one day ..... hr. ..... min.

9. Birthplace Kansas City (City, town, or county) Mo. 0 (State or foreign country)

10. Usual occupation None 9

11. Industry or business 0

FATHER
12. Name Harold Meisner
13. Birthplace — Unknown — (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name LOVIE HICKMAN
15. Birthplace Clay County (City, town, or county) Missouri (State or foreign country)

16. (a) Informant Record Clerk
(b) Address K.C. General Hospital

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 6-7-41 (Month) (Day) (Year)
(c) Place: burial or cremation Reeds

18. (a) Signature of funeral director Wm A Lohmeyer
(b) Address KC Gen Hospt

19. (a) Dec. 31, 1940 (Date received local registrar) (b) ..... (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month ..... day 10-29-40
year ..... hour 10:00 minute 00 A.M.

21. I hereby certify that I attended the deceased from 5-15 A. ..... Coroner, 19..., to ..... 19...;
that I last saw he alive on ..... 19...;
and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death	
Due to Prematurity	
Due to	
Other conditions (Include pregnancy within 3 months of death)	

Major findings:
Of operations .....
Of autopsy Yes

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 [illegible] (M. D. or other) .....
Address K.C. Mo. Date signed .....

(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.....

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

working under my personal supervision.

Signed.....

Licensed Embalmer No.....

P. O. Address.....

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

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