

FILED JAN 30 1943  
Registration District No. 149

Primary Registration District No. 1002

Registrar's No. 261

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:  
2335 Cleveland /  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution \_\_\_\_\_  
(Specify whether \_\_\_\_\_)  
In this community 19 years  
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. 2335 Cleveland  
(If rural, give location)  
(e) If foreign born, how long in U. S. A.? 0 years.

3. (a) PRINT

FULL NAME Oscar Nickerson  
(b) If veteran, name war no  
(c) Social Security No. no

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan day 11  
year 1943 hour 9:10 minute a M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_  
Deputy Coroner, 19\_\_\_\_  
that I last saw him alive on \_\_\_\_\_, 19\_\_\_\_  
and that death occurred on the date and hour stated above.

Immediate cause of death acute dilatation of heart  
Duration \_\_\_\_\_

Due to \_\_\_\_\_  
Due to 95c

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

Major findings:  
Of operations \_\_\_\_\_  
Of autopsy inspection - history  
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)  
(e) Means of injury \_\_\_\_\_  
23. Signature L. H. Richardson (M.D. or other)  
Address 1832 Pine Date signed 1-16-43

4. Sex male 5. Color or race Negro

6. (a) Single, widowed, married, divorced, separate \_\_\_\_\_  
(b) Name of husband or wife Anna Mickerson  
(c) Age of husband or wife if alive 70 years

7. Birth date of deceased About 1875  
(Month) (Day) (Year)

8. AGE: Years About 68 Months \_\_\_\_\_ Days \_\_\_\_\_  
If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

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

10. Usual occupation Janitor

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

MOTHER FATHER { 12. Name Unknown  
13. Birthplace Unknown  
(City, town, or county) (State or foreign country)  
14. Maiden name Unknown  
15. Birthplace Unknown  
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature Leona Jones

(b) Address 2104 Washbash

17. (a) Burial (b) Date thereof 1-19-43  
(Burial, cremation, or removal) (Month) (Day) (Year)  
(c) Place: burial or cremation Blue Ridge Lawn

18. (a) Signature of funeral director R. H. H. H.

(b) Address 1513 Iowa

19. (a) 1-18-43 (b) M. M. Crowe  
(Date received local registrar) (Registrar's signature)

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. PHYSICIANS should state EXACTLY. PHYSICIANS should state EXACTLY.

**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.....

*L. P. Harris, S*

Licensed Embalmer No. *3388*

P. O. Address *K. C. Mo*

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

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