S. No. 2
M—8-43
7. 5-17-39
I X37823

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 5327

FILED FEB 17 1945

Registration District No. 1459

Primary Registration District No. 1002

Registrar's No. 662

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

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

2. USUAL RESIDENCE OF DECEASED:

(a) State: Missouri (b) County: Jackson 118

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

(d) Street No.: 2318 Bellefontaine
(If rural, give location)

(e) Citizen of foreign country: no (Yes or No)
If yes, name country: 0

3. (a) PRINT FULL NAME: Homer Ernest Sickler

3. (b) If veteran, name war: no

3. (c) Social Security No.: none

4. Sex: male

5. Color or race: white

6. (a) Single, widowed, married, divorced: child

6. (b) Name of husband or wife:

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

7. Birth date of deceased: Feb. (Month) 5th. (Day) 1945 (Year)

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

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

10. Usual occupation: infant.

11. Industry or business:

FATHER
12. Name: Alfred Sickler
13. Birthplace: Mo. (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name: Joan Mc Kay
15. Birthplace: Ark. (City, town, or county) (State or foreign country)

16. (a) Informant: Alfred Sickler
(b) Address: 2318 Bellefontaine, K.C. Mo.

17. (a) burial (Burial, cremation, or removal) (b) Date thereof: 2/10/45 (Month) (Day) (Year)
(c) Place: burial or cremation: Mt. Washington Cem

18. (a) Signature of funeral director: Farp Funeral Home
(b) Address: 4139 E. 15th. St. K.C. Mo.

19. (a) 2-9-45 (Date received local registrar) (b) R. E. Brown (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb day 7 year 1945 hour 4 minute 20 P.M.

21. I hereby certify that I attended the deceased from Feb 5, 1945 to Feb 7, 1945 that I last saw him alive on Feb. 7, 1945 and that death occurred on the date and hour stated above.

Immediate cause of death	Duration
Toxemia Myocardial insufficiency	2 days.
Due to: Maternal Nephritis Toxemia	
Due to:	
Other conditions (Include pregnancy within 3 months of death): 157	
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: [illegible] (M. D. or other)
Address: 4712 E. 24th Date signed 2/8/45

361 (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 John B. Eaup

Licensed Embalmer No. 2955

P. O. Address R.C. 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, fact should be so stated above.