

V. S. No. 2  
FORM-5-43  
Rev. 5-17-39  
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26454

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI  
1945 STANDARD CERTIFICATE OF DEATH

State File No. \_\_\_\_\_  
Registrar's No. 3451

FILED SEP 1 1945

Registration District No. 149

Primary Registration District No. 1002

1. PLACE OF DEATH:

(a) County Jackson

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

(c) Name of hospital or institution: General Hospital #2 0  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 18 hours  
(Specify whether \_\_\_\_\_)

In this community 1 day  
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson 48

(c) City or town Kansas City 3  
(If outside city or town limits, write "RURAL")

(d) Street No. 707 1/2 E. 14th St. ?  
(If rural, give location)

(e) Citizen of foreign country? NO (Yes or No) 0  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME JULIUS HICKS JUNIOR

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

4. Sex Male 2 5. Color or race Negro 6. (a) Single, widowed, married, divorced, Single 0

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

7. Birth date of deceased 4-11-45  
(Month) (Day) (Year)

MEDICAL CERTIFICATION

20. DATE OF DEATH August 14 1945 Month day  
year 6:00 hour D.M. minute M.

21. I hereby certify that I attended the deceased from 8-14-45  
1:30 a.m. 19 8-14-45 6p.m. 19 \_\_\_\_\_  
that I last saw him im alive on 8-14-45 19 \_\_\_\_\_  
and that death occurred on the date and hour stated above.

8. AGE:

Years	Months	Days	If less than one day
	<u>4</u>	<u>3</u>	_____ hr. _____ min.

Immediate cause of death Bronchopneumonia

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

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

Other conditions (Include pregnancy within 3 months of death) 107

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

10. Usual occupation none

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

12. Name Julius Hicks

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

14. Maiden name Ruth Clayton

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

PHYSICIAN \_\_\_\_\_

Underline the cause to which death should be charged statistically.

Major findings: Of operations \_\_\_\_\_

Of autopsy Same as above

16. (a) Informant Record Clerk Gen. Hosp. #2

(b) Address \_\_\_\_\_

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 8-17-45  
(Month) (Day) (Year)

(c) Place: burial or cremation Westlawn N. O. H. Co.

18. (a) Signature of funeral director W. Jones

(b) Address 440 State

19. (a) 8-17-45 (b) Geraldine Holmes  
(Data received local registrar) (Registrar's signature)

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) (Means of injury) 0

23. Signature H. Turner M.D.  
Address Pen. Hosp. #2 Date signed 8-16-45

(Licensed Embalmer's Statement on Reverse Side)

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

*Eugene English*

Licensed Embalmer No. *40105*

P. O. Address *416 State Ave. K.C.*

**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.**