

V. S. No. 2  
OM-8-43  
Rev. 5-17-39  
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29626

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. \_\_\_\_\_

FILED OCT 1 1945

3873

Registration District No. 149

Primary Registration District No. 1002

Registrar's No. \_\_\_\_\_

1. PLACE OF DEATH:

(a) County Jackson  
(b) City or town Kansas  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
709 Washington  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution \_\_\_\_\_  
(Specify whether  
In this community 6 Years  
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County Jackson #8  
(c) City or town Kansas City Mo 3  
(If outside city or town limits, write "RURAL")  
(d) Street No. 709 Washington 8  
(If rural, give location)  
(e) Citizen of foreign country? No (Yes or No)  
If yes, name country No

3. (a) PRINT Jacob Dickes  
FULL NAME

3. (b) If veteran, name war Do not know  
3. (c) Social Security No. Do not know

4. Sex Male 5. Color or race White  
6. (a) Single, widowed, married, divorced Do not know  
6. (b) Name of husband or wife Do  
6. (c) Age of husband or wife if alive \*\*\*\*\* years  
7. Birth date of deceased 1859  
(Month) (Day) (Year)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept. day 17  
year 1945 hour 6 minute A M.

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

Immediate cause of death Coronary sclerosis  
Due to Coronary sclerosis  
Due to \_\_\_\_\_

8. AGE: Years 86 Months \_\_\_\_\_ Days \_\_\_\_\_  
If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

Other conditions (include pregnancy within 3 months of death) AV

9. Birthplace Do not know  
(City, town, or county) (State or foreign country)

10. Usual occupation Labor

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

MOTHER FATHER { 12. Name Do not know  
13. Birthplace \*\*\*\*\* (City, town, or county) (State or foreign country) 9  
14. Maiden name Do not know  
15. Birthplace \*\*\*\*\* (City, town, or county) (State or foreign country) 9

16. (a) Informant Coroner Office  
(b) Address Kansas City Mo

17. (a) School (b) Date thereof Sept 19-45  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation T.C. College Osteopathy School

18. (a) Signature of funeral director Passantino Bros  
(b) Address Kansas City Mo

19. (a) 9-19-45 (b) Deraldine Holmes  
(Date received local registrar) (Registrar's signature)

Major findings: Of operations \_\_\_\_\_  
Of autopsy no  
History & Inspection

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 3

23. Signature Jamuel Walker (M. D. or other) \_\_\_\_\_  
Address 1424 Bay City Date signed 9-17-45

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

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**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 Frances Walton.....

Licensed Embalmer No..... 2744.....

P. O. Address..... Kansas City 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.**