

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. _____

1083

FILED MAR 25 1947
Registration District No. 149

Primary Registration District No. 1002

Registrar's No. _____

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:
705 East 62nd St.
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution no. (Specify whether
In this community 9 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. 705 East 62nd Street,
(If rural, give location)
(e) Citizen of foreign country? no. (Yes or No)
If yes, name country X

3. (a) PRINT FULL NAME John T. Hickerson

3. (b) If veteran, name war World War #1 3. (c) Social Security No. no.

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

6. (b) Name of husband or wife Mrs. Sarah Hickerson 6. (c) Age of husband or wife if alive dec. years

7. Birth date of deceased November 17 1866
(Month) (Day) (Year)

8. AGE: Years 80 Months 3 Days 22 If less than one day hr. min.

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

10. Usual occupation Physician

11. Industry or business X

MOTHER FATHER

12. Name Allen Hickerson

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

14. Maiden name Paulina Gurgin

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

16. (a) Informant Roy Hickerson,

(b) Address 705 E. 62nd St., Kansas City, Mo.

17. (a) removal (b) Date thereof 3-10-47
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Centralia, Missouri,

18. (a) Signature of funeral director Stine & McClure

(b) Address 3235 Gillham Plaza, K. C., Mo.

19. (a) 3-10-47 (b) Geraldine Holme
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 10
year 1947 hour 3:00 minutes A. M.

21. I hereby certify that I attended the deceased from 1947 to 1947
that I last saw him alive on 3/9 and that death occurred on the date and hour stated above.

Immediate cause of death Myocardial failure chronic

Due to remedy

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations 93
Of autopsy

Duration

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) (c) Means of injury

23. Signature H. Trippe (M. D. or other) MD

Address 1014 Algon Date signed 3/10/47

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

Dr. H. C. Tripp

any other party

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 *J. Clair Suggard*
Licensed Embalmer No. *4179*
P. O. Address *N. 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.