

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATHState File No. **4015**
Registrar's No. **293**Registration District No. **42**Primary Registration District No. **1000**

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

1. PLACE OF DEATH:

(a) County Buchanan
 (b) City or town St. Joseph
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution:
1523 Messanie Street
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution _____ (Specify whether)
 In this community 50 Years
 years, months or days

3. (a) PRINT
FULL NAMELouise Hicks3. (b) If veteran,
name war No3. (c) Social Security
No. None4. Sex Female
5. Color or
race Negro6. (a) Single, widowed, married,
divorced Widowed6. (b) Name of husband or wife
Morgan Hicks6. (c) Age of husband or wife if
alive _____ years7. Birth date of deceased May 16 1880
(Month) (Day) (Year)8. AGE: Years Months Days If less than one day
✓ 67 9 26 hr. _____ min.9. Birthplace St. Joseph Missouri
(City, town, or county) (State or foreign country)10. Usual occupation Housewife11. Industry or business Housewife12. Name Sam Gray13. Birthplace Unknown Unknown
(City, town, or county) (State or foreign country)14. Maiden name Clara (Unknown)15. Birthplace Unknown Unknown
(City, town, or county) (State or foreign country)16. (a) Informant Mrs. William Copeland(b) Address 1810 Messanie Street17. (a) Burial (b) Date thereof 3-9-1948
(Burial, cremation, or removal) (Month) (Day) (Year)(c) Place: burial or cremation City Cemetery18. (a) Signature of funeral director Wm. H. Alexander(b) Address 1602 Messanie St. St. Joe. Mo.19. (a) 3-11-48 (b) E. L. Jenkins
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Buchanan //
 (c) City or town St. Joseph /
 (If outside city or town limits, write "RURAL")
 (d) Street No. 1523 Messanie Street 7
 (If rural, give location)
 (e) Citizen of foreign country? No (Yes or No)
 If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 6
 year 1948 hour 6 minute 50 A. M.

21. I hereby certify that I attended the deceased from March 1 - 6, 1948
 to March 6, 1948
 that I last saw her alive on March 6, 1948
 and that death occurred on the date and hour stated above.

Immediate cause of death

Chronic Mitral Insufficiency 9 few
months

Due to _____

Due to _____

Other conditions
(Include pregnancy within 3 months of death)Major findings:
Of operations _____

Of autopsy _____

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 _____

23. Signature E. L. Jenkins (M. D. or other) MD
 Address 1091 W. W. Mo Date signed 3/9/48

(Licensed Embalmer's Statement on Reverse Side) St. Joseph, Mo

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..... *Wm. H. Alexander*

Licensed Embalmer No. *4450*

P. O. Address..... *St. Joseph, 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.