

Registration District No. **325**

Primary Registration District No. **6099**

Registrar's No. **16**

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

1. PLACE OF DEATH:

(a) County Schuyler  
(b) City or town Queen City (Rural)  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: 1  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution. —  
In this community 60 yrs  
years, months or days (Specify whether)

3. (a) PRINT FULL NAME MAGNOLA FLICK

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

4. Sex Female 5. Color or race white 6. (a) Single, widowed, married, divorced, married  
6. (b) Name of husband or wife Wm. B. Flick 6. (c) Age of husband or wife if alive 83 years  
7. Birth date of deceased Sept 27 1877  
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>70</u>	<u>6</u>	<u>22</u>	hr. <u>—</u> min. <u>—</u>

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

10. Usual occupation housewife

11. Industry or business —

MOTHER FATHER {  
12. Name Wm. Freely 9  
13. Birthplace not known (City, town, or county) (State or foreign country)  
14. Maiden name Sarah Jane Courser  
15. Birthplace not known (City, town, or county) (State or foreign country)

16. (a) Informant J. M. Flick  
(b) Address Queen City  
17. (a) Burial (b) Date thereof 4/21/48  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Jan cemetery  
18. (a) Signature of funeral director Wm G West  
(b) Address Queen City Mo

19. (a) Apr 21/48 (b) Miss. West  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Schuyler 98  
(c) City or town Queen City (Rural)  
(If outside city or town limits, write "RURAL")  
(d) Street No. — (If rural, give location)  
(e) Citizen of foreign country? no (Yes or No)  
If yes, name country —

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 19th  
year 1948 hour 3 minute 15 P.M.

21. I hereby certify that I attended the deceased from January 15th, 1948 to April 19, 1948.  
that I last saw her alive on April 19, 1948.  
and that death occurred on the date and hour stated above.

Immediate cause of death Glomerulonephritis  
Due to Renal Failure  
Due to Hypertension

Duration
<u>3 months</u>
<u>3 years</u>
<u>10 years</u>

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

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?

While at work? (Specify type of place) (c) Means of injury —

23. Signature Ed. Stuckland (If D. O. other)  
Address Queen City, Mo Date signed 4/20/48

RECEIVED

District Health Officer No. 10

District File Number 4-48-771

Date Filed APR 27 1948

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 Self

Registered Apprentice No. \_\_\_\_\_

working under my personal supervision.

Signed Wm O West

Licensed Embalmer No. 2882

P. O. Address Queencity 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.