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5-17-39  
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DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS  
FILED DEC 11 1948  
Registration District No. 149

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH  
Primary Registration District No. 1002

36606  
State File No. \_\_\_\_\_  
Registrar's No. 4825

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

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:  
3022 Park Avenue  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution none  
In this community 20 years  
years, months or days (Specify whether)

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. 3022 Park Avenue  
(If rural, give location)  
(e) Citizen of foreign country? no (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME Sarah M. Bond HICKS  
3. (b) If veteran, name war no  
3. (c) Social Security No. none

MEDICAL CERTIFICATION  
20. DATE OF DEATH: Month November day 25  
year 1948 hour 2 minute 20 P. M.  
21. I hereby certify that I attended the deceased from  
March 20, 1939, to November 25, 1948;  
that I last saw her alive on November 25, 1948;  
and that death occurred on the date and hour stated above.

4. Sex female 5. Color or race white  
6. (a) Single, widowed, married, 2 divorced widowed  
6. (b) Name of husband or wife James Hicks  
6. (c) Age of husband or wife if alive \_\_\_\_\_ years  
7. Birth date of deceased May 11, 1857  
(Month) (Day) (Year)

Immediate cause of death \_\_\_\_\_ Duration 2 days  
Congestive heart failure  
Due to Cerebral hemorrhage 2 days  
Hypertensive heart disease  
Due to Arterio-sclerosis, general  
Other conditions \_\_\_\_\_  
(Include pregnancy within 3 months of death)

8. AGE: Years Months Days If less than one day  
91 6 14 hr. min.  
9. Birthplace Miller County, Missouri  
(City, town, or county) (State or foreign country)  
10. Usual occupation At home

Major findings: 93 D  
Of operations \_\_\_\_\_  
Of autopsy \_\_\_\_\_  
PHYSICIAN \_\_\_\_\_  
Underline the cause to which death should be charged statistically.

MOTHER FATHER {  
11. Industry or business \_\_\_\_\_  
12. Name Ambrose Brockman  
13. Birthplace Unknown  
(City, town, or county) (State or foreign country)  
14. Maiden name Unknown  
15. Birthplace Unknown  
(City, town, or county) (State or foreign country)  
16. (a) Informant Mrs. Sidney Bond  
(b) Address 3022 Park Ave., K. C., Mo.  
17. (a) Removal (b) Date thereof 11-27-48  
(Burial, cremation, or removal) (Month) (Day) (Year)  
(c) Place: burial or cremation Eldon, Missouri  
18. (a) Signature of funeral director Melody McGilley-Eylar  
(b) Address Kansas City, Missouri  
19. (a) 11-26-48 (b) Geraldine Holman  
(Date 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?  
Robert Fansen  
(Specify type of place) (e) Means of injury \_\_\_\_\_  
While at work? \_\_\_\_\_  
23. Signature Robert Fansen (M. D. or other)  
Address 2220 E 31st St Date signed 11-25-48

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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 *Glen E. Heck*

Licensed Embalmer No. *4063*

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.**