

FILED JUN 3 1950

THE DIVISION OF HEALTH OF THE STATE OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **16782**
2239

BIRTH NO. _____ REG. DIST. NO. **149** PRIMARY REG. DIST. NO. **1002** Registrar's No. _____

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|---|--|--|--|
| 1. PLACE OF DEATH a. COUNTY Jackson | | 2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Missouri b. COUNTY Jackson | |
| b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Kansas City | | c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Kansas City | |
| c. LENGTH OF STAY (in this place) 15 yrs. | | d. STREET ADDRESS (If rural, give location) 704 W. 75th Terrace | |
| d. FULL NAME OF HOSPITAL OR INSTITUTION Trinity Lutheran Hospital | | | |

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|--|--|---|--|--|--|---|--|
| 3. NAME OF DECEASED (Type or Print) a. (First) Troy | | b. (Middle) - | | c. (Last) Hixon | | 4. DATE OF DEATH (Month) (Day) (Year) May 16, 1950 | |
| 5. SEX male | | 6. COLOR OR RACE white | | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) married | | 8. DATE OF BIRTH Dec. 11, 1891 | |
| 9. AGE (In years last birthday) 56.55 | | 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Machinist | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) Ohio | |
| 12. CITIZEN OF WHAT COUNTRY? USA | | 13a. FATHER'S NAME ---- | | 13b. MOTHER'S MAIDEN NAME Lena -- | | 14. NAME OF HUSBAND OR WIFE Mary Florence Hixon | |

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|---|--|---|--|--|--|---------|--|
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) yes W. W. 2 | | 16. SOCIAL SECURITY NO. 487-10-4068 | | 17. INFORMANT'S SIGNATURE OR NAME Mrs. Mary F. Hixon, 704 W. 75th Terr., K.C., Mo. | | ADDRESS | |
|---|--|---|--|--|--|---------|--|

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|--|--|---|--|--|--|----------------------------------|--|
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) <i>*This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.</i> | | MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Myocardial Infarction | | | | INTERVAL BETWEEN ONSET AND DEATH | |
| | | ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Coronary Artery Thrombosis | | | | 1 wk | |
| | | DUE TO (c) arteriosclerotic heart disease | | | | 42⁰⁰ | |
| | | II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. | | | | | |

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|--|--|--|--|---|--|
| 19a. DATE OF OPERATION | | 19b. MAJOR FINDINGS OF OPERATION | | 20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT SUICIDE HOMICIDE (Specify) | | 21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) | |

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|---|--|--|--|----------------------------|--|
| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) | | 21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21f. HOW DID INJURY OCCUR? | |
|---|--|--|--|----------------------------|--|

22. I hereby certify that I attended the deceased from **15 May, 1950**, to **16 May, 1950**, that I last saw the deceased alive on **16 May, 1950**, and that death occurred at **7:24 p.m.**, from the causes and on the date stated above.

| | | | | | |
|---|--|--|--|------------------|--|
| 23a. SIGNATURE Edw. H. Fischer (Degree or title) | | 23b. ADDRESS 2025 Adelgit Wokg, 16 May 50 | | 23c. DATE SIGNED | |
|---|--|--|--|------------------|--|

| | | | | | | | |
|--|--|-----------------------------|--|---|--|---|--|
| 24a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 24b. DATE 5/18/50 | | 24c. NAME OF CEMETERY OR CREMATORY Floral Hills | | 24d. LOCATION (City, town, or county) (State) Kansas City, Missouri | |
|--|--|-----------------------------|--|---|--|---|--|

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|--|--|---|--|--|--|---------|--|
| DATE REC'D BY LOCAL REG. 5-17-50 | | REGISTRAR'S SIGNATURE Sheldine Holmes | | 25. FUNERAL DIRECTOR'S SIGNATURE STINE & McCLURE, Kansas City, Mo. | | ADDRESS | |
|--|--|---|--|--|--|---------|--|

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

1961 8 MNC

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 _____

working under my personal supervision.

Student Embalmer No.

Signed

L J Allen

Signed.....
Student Embalmer

Licensed Embalmer No. *1415*

P. O. Address *ACMS*

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.