

S. No. 300
v. 10.48

FILED OCT 24 1950

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

33030

State File No. _____

BIRTH NO. _____ REG. DIST. NO. 77 PRIMARY REG. DIST. NO. 3016 Registrar's No. 234

1. PLACE OF DEATH a. COUNTY <u>Cole</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Mo</u> b. <u>PACKSON</u>	
b. CITY (If outside corporate limits, write RURAL and give OR TOWN <u>Jefferson City Mo</u>)		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Kansas City Mo.</u>	
c. LENGTH OF STAY (In this place) <u>4 weeks</u>		Mo. <u>3648</u>	
d. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION <u>St Marys Hospital</u>		d. STREET ADDRESS (If rural, give location) <u>4238 Tracy.</u>	

3. NAME OF DECEASED (Type or Print)	a. (First) <u>Gertrude</u>	b. (Middle) <u>Mae</u>	c. (Last) <u>Hicks.</u>	4. DATE OF DEATH (Month) (Day) (Year) <u>Oct 19 1950</u>
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5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>Aug 28 1893</u>	9. AGE (In years last birthday) <u>57</u>	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 10 HRS. Hours _____ Min. _____
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife.</u>	10b. KIND OF BUSINESS OR INDUSTRY _____	11. BIRTHPLACE (State or foreign country) <u>Altoona Mo</u>	12. CITIZEN OF WHAT COUNTRY? <u>U S A</u>
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13a. FATHER'S NAME <u>Henry Harrison</u>	13b. MOTHER'S MAIDEN NAME <u>Minnie Goodrich</u>	14. NAME OF HUSBAND OR WIFE <u>Willard Hicks.</u>
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) _____	16. SOCIAL SECURITY NO. _____	17. INFORMANT'S SIGNATURE OR NAME <u>Willard Hicks</u>	ADDRESS <u>4238 Tracy K. C. MO.</u>
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18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asphyxia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Abdominal Carcinomatosis</u> ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Adenocarcinoma, Rt. & Lt.</u> DUE TO (c) <u>Ovary.</u> II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>Sligoabdominal Fistula</u>		INTERVAL BETWEEN ONSET AND DEATH <u>6 mos.</u> <u>18 mos.</u> <u>175X</u> <u>6 weeks.</u>
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19a. DATE OF OPERATION <u>5-24-49</u>	19b. MAJOR FINDINGS OF OPERATION <u>Bilateral Ovarium Carcinoma with Spread to Uterus.</u>	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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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) _____
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.) _____	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 May 11, 1949, to Oct. 19, 1950, that I last saw the deceased alive on Oct 19, 1950, and that death occurred at 1:30 P.m., from the causes and on the date stated above.

23a. SIGNATURE <u>H. M. Wiley</u> (Degree or title) <u>M.D.</u>	23b. ADDRESS <u>Jefferson City, Mo.</u>	23c. DATE SIGNED <u>10-20-50</u>
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24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>	24b. DATE <u>Oct 23-1950</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Neosoma + Jones F. H. Cemetery</u>	24d. LOCATION (City, town, or county) (State) <u>Kansas City Mo.</u>
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DATE REC'D BY LOCAL REG. <u>Oct 20-1950</u>	REGISTRAR'S SIGNATURE <u>R.P. Darrin MD - MRC</u>	25. FUNERAL DIRECTOR'S SIGNATURE <u>Thorne Gordon</u>	ADDRESS <u>Jefferson City Mo</u>
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(Licensed Embalmer's Statement on Reverse Side)

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

NOV 29 1950

RECEIVED 10.23.50

DISTRICT HEALTH OFFICE No. 3

District File Number _____

Date Filed 10.23.50

NOV 23 1950

NOV 24 1959

MAR 6 1963

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 *Fred P. Dulle*

Signed.....
Student Embalmer

Licensed Embalmer No. *3890*

P. O. Address *Jefferson 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.