

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

20491

State File No.

2636

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

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 town or township) Kansas City,		c. CITY (If outside corporate limits, write RURAL and give township) Kansas City	
c. LENGTH OF STAY (In this place) 1-1/2		d. STREET ADDRESS (If rural, give location) 3726 Washington	
d. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION Memorial Hospital Medical Center			

3118
340
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3. NAME OF DECEASED a. (First) Chalmers		b. (Middle) Dee		c. (Last) Hicks		4. DATE OF DEATH (Month) (Day) (Year) 6 9 52	
5. SEX M	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Divorced 2		8. DATE OF BIRTH July 6, 1883		9. AGE (In years last birthday) 68	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Barber		10b. KIND OF BUSINESS OR INDUSTRY Varsity Barber Shop		11. BIRTHPLACE (State or foreign country) Nashville Tenn.		12. CITIZEN OF WHAT COUNTRY U.S.A.	

13a. FATHER'S NAME Unknown		13b. MOTHER'S MAIDEN NAME Unknown		14. NAME OF HUSBAND OR WIFE Norah Hicks	
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 511-10-8032		17. INFORMANT'S SIGNATURE OR NAME Mrs. Lee R. Johnson		ADDRESS 5600 Newton Rd. Mission, Kansas	
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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, asthma, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH	
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Acute Heart Failure		DUE TO (b) Chronic Myocarditis				7 days	
ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.		DUE TO (c)				10 yrs	
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.						42-2	

19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input 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)	
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Minute)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?	
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22. I hereby certify that I attended the deceased from Feb 1948 to June 9, 1952, that I last saw the deceased alive on June 9, 1952 and that death occurred at 11:30 A.M., from the causes and on the date stated above.

23a. SIGNATURE S. R. Maser (Degree or title) D.M.D.		23b. ADDRESS Mission, Mo		23c. DATE SIGNED 6/9/52	
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24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE 6-11-52		24c. NAME OF CEMETERY OR CREMATORY Mt. Moriah		24d. LOCATION (City, town, or county) (State) K.C. Mo.	
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DATE REC'D BY LOCAL REG. 6-11-52		REGISTRAR'S SIGNATURE Gerardine Helms		FUNERAL DIRECTOR'S SIGNATURE Paul Amos		ADDRESS Funeral Home Shawnee, Kans.	
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(Licensed Embalmer's Statement on Reverse Side)

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

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 _____

..... Student Embalmer No.
working under my personal supervision.

Student
Student Embalmer

Signed Ed Paulinus

Licensed Embalmer No. 4385

P. O. Address Shawnee, Kans

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.