S. No. 300
v. 10.48

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 28

FILED FEB 11 1953

BIRTH NO. _____ REG. DIST. NO. 1 PRIMARY REG. DIST. NO. 3000 Registrar's No. 53

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1. PLACE OF DEATH
a. COUNTY: Adair
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Kirksville
c. LENGTH OF STAY (in this place): 4 das
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Stickler Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Mo.
b. COUNTY: Adair
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Kirksville 0013
d. STREET ADDRESS (If rural, give location): 1315 E. Randolph 0

3. NAME OF DECEASED (Type or Print)
a. (First): Ida
b. (Middle): May
c. (Last): Ikerd

4. DATE OF DEATH (Month) (Day) (Year): Feb. 2, 1953

5. SEX: F 1
6. COLOR OR RACE: W
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Widowed 2
8. DATE OF BIRTH: July 4, 1863
9. AGE (In years last birthday): 89 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Home
10b. KIND OF BUSINESS OR INDUSTRY: Home
11. BIRTHPLACE (City and State or Foreign Country): Hancock, Ohio 1
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13a. FATHER'S NAME: John Miller
13b. MOTHER'S MAIDEN NAME: Mary Jane Bushang
14. NAME OF HUSBAND OR WIFE: Henry Low Ikerd

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service): X
16. SOCIAL SECURITY NO.: none
17. INFORMANT'S SIGNATURE OR NAME — ADDRESS: Leo Ikerd, Kirksville, Mo.

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, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Senility — 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): anemia — 10 yrs
DUE TO (c): 293X

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

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) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 6-25, 1949, *to* Feb. 2, 1953, *that I last saw the deceased alive on* Feb. 2, 1953, *and that death occurred at* 5:30 *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): R. D. Stickler MD
23b. ADDRESS: Kirksville, Mo.
23c. DATE SIGNED: 2-3-53

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: 2/4/53
24c. NAME OF CEMETERY OR CREMATORY: Maple Hills
24d. LOCATION (City, town, or county) (State): Adair Co., Mo.

DATE REC'D BY LOCAL REG.: 2-7-53
REGISTRAR'S SIGNATURE: Kate Lambert 1-0
25. FUNERAL DIRECTOR'S SIGNATURE — ADDRESS: Kirksville, Mo.

(Licensed Embalmer's Statement on Reverse Side)

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

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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 .....

....., Student Embalmer No. .....,

working under my personal supervision.

Student .....
Student Embalmer

Signed Richard W. Bandall

Licensed Embalmer No. 4866

P. O. Address Kirksville, 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.