THE DIVISION OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

14243

State File No. 1700

FILED APR 16 1953

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

1. PLACE OF DEATH
a. COUNTY: Jackson
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Kansas City
c. LENGTH OF STAY (in this place): unk
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): General Hospital #1

2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission).
a. STATE: Mo
b. COUNTY: Jackson
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Kansas City 3458
d. STREET ADDRESS (If rural, give location): 2734 Holly

3. NAME OF DECEASED (Type or Print)
a. (First): Leslie
b. (Middle): E
c. (Last): Hicks

4. DATE OF DEATH (Month) (Day) (Year): 3-25-53

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married
8. DATE OF BIRTH: 4-24-1916
9. AGE (In years last birthday): 36 — 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): auto electrician
10b. KIND OF BUSINESS OR INDUSTRY: Hicks Electric Co.
11. BIRTHPLACE (State or foreign country): Mo
12. CITIZEN OF WHAT COUNTRY?: USA

13a. FATHER'S NAME: Wm Hicks
13b. MOTHER'S MAIDEN NAME: Caroline Sharp
14. NAME OF HUSBAND OR WIFE: Belle Hicks

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): yes (If yes, give war or dates of service): W.W. #2
16. SOCIAL SECURITY NO.: unk
17. INFORMANT'S SIGNATURE OR NAME: Katie Hicks — ADDRESS: KC 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): Pending Lab Examination

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b)

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION: 123
20. AUTOPSY? YES [X] NO [ ]

21a. ACCIDENT SUICIDE HOMICIDE (Specify): accident
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.): Street
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE): Kansas City Jackson Mo
21d. TIME OF INJURY (Month) (Day) (Year) (Hour): 3-18-53 m.
21e. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
21f. HOW DID INJURY OCCUR?: Automobile accident

22. *I hereby certify that I attended the deceased from _____, 19___, to _____, 19___, that I last saw the deceased alive on _____, 19___, and that death occurred at 4:10P m., from the causes and on the date stated above.*

23a. SIGNATURE Geo. C. Kealhofer (Degree or title): Geo C Kealhofer Jr Deputy Coroner 3
23b. ADDRESS: 4050 Broadway Kcmo
23c. DATE SIGNED: 3-26-53

24a. BURIAL, CREMATION, REMOVAL (Specify): Removal
24b. DATE: 3-27, 1953
24c. NAME OF CEMETERY OR CREMATORY: Forest Hill
24d. LOCATION (City, town, or county) (State): Kansas City Mo

DATE REC'D BY LOCAL REG.: 3-27-53
REGISTRAR'S SIGNATURE: Geraldine Smith
25. FUNERAL DIRECTOR'S SIGNATURE: Daniels Bros — ADDRESS: KC Kans.

(Licensed Embalmer's Statement on Reverse Side)

APR 16 1935

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 F. S. Malton

Signed.....
Student Embalmer

Licensed Embalmer No. 2744

P. O. Address KC Mo

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to compl the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.