

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

33469

State File No. _____

FILED OCT 19 1955

BIRTH NO. _____ REG. DIST. NO. 149 PRIMARY REG. DIST. NO. 1002 Registrar's No. 4168

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) KANSAS CITY		c. LENGTH OF STAY (in this place) 2 years		c. CITY OR TOWN KANSAS CITY	
d. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION VETERANS ADMINISTRATION HOSPITAL		* STREET ADDRESS (If rural, give location) 1019 JEFFERSON		d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input type="checkbox"/>	

3. NAME OF DECEASED (Type or Print) a. (First) PERCY			b. (Middle) W.			c. (Last) PICKLES			4. DATE OF DEATH (Month) (Day) (Year) September 25, 1955		
5. SEX Male		6. COLOR OR RACE White		7. MARRIED, NEVER MARRIED, 3 WIDOWED, DIVORCED (Specify) Divorced		8. DATE OF BIRTH January 3, 1888		9. AGE (In years last birthday) 67		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most working life, even if retired) Retired				10b. KIND OF BUSINESS OR INDUSTRY Operator of Dairy		11. BIRTHPLACE (City and State or Foreign Country) Nebraska			12. CITIZEN OF WHAT COUNTRY? U.S.A.		

13a. FATHER'S NAME John Pickles			13b. MOTHER'S MAIDEN NAME Stella Field			14. NAME OF HUSBAND OR WIFE Jo Sheffield		
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. (If yes, give year or dates of service) WW I		17. INFORMANT'S SIGNATURE OR NAME John Morford		ADDRESS Lincoln, Nebr.	
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18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)		MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
<p>*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.</p>		I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH*(a) Myocardia - infarctus						593 X	
		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.							

19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
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21a. ACCIDENT SUICIDE HOMICIDE (Specify) Natural		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) VA		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 Sept. 25, 1955, to Sept. 25, 1955, ~~XXXXXX~~ and that the death occurred at 9:15 Pm., from the causes and on the date stated above.

23a. SIGNATURE (Design or title) HUGH H. OWEN, M.D. Coroner		23b. ADDRESS 1056 Rialto Bldg, K. C. Mo.		23c. DATE SIGNED 9/26/55	
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24a. BURIAL, CREMATION, REMOVAL (Specify) Removal		24b. DATE 9-26-55		24c. NAME OF CEMETERY OR CREMATORY Sheridan		24d. LOCATION (City, town, or county) (State) Auburn, Nebraska	
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DATE REC'D BY LOCAL REG. 9-26-55		REGISTRAR'S SIGNATURE <i>Neva Marshall</i>		25. FUNERAL DIRECTOR'S SIGNATURE <i>D.W. Newsome</i>		ADDRESS K. C. Mo.	
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(Licensed Embalmer's Statement on Reverse Side)

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

300
48

OCT 20 1951

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.....
Signature of Student Embalmer

Signed *Robert E. Henson*.....

Licensed Embalmer No. *48*.....

P. O. Address: *K.P. 2*.....

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (to comply with the above constitutes grounds for revocation of license).
If embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.