

FILED FEB 14 1956

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **1806**

BIRTH NO. _____ REG. DIST. NO. **170** PRIMARY REG. DIST. NO. **5625** Registrar's No. **17**

1. PLACE OF DEATH a. COUNTY Laclede		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY Laclede	
b. CITY (If outside corporate limits, write RURAL and give town(ship)) OR TOWN RURAL Auglize T.S.	c. LENGTH OF STAY (in this place) 2 Month	c. CITY OR TOWN Sleeper, Mo.	d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
d. FULL NAME OF HOSPITAL OR INSTITUTION Sleeper, Mo.		e. STREET ADDRESS (If rural, give location) Sleeper, Mo.	

3. NAME OF DECEASED (Type or Print) a. (First) Martha b. (Middle) Jane c. (Last) Hicks			4. DATE OF DEATH (Month) (Day) (Year) Feb. 4, 1956		
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5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed	8. DATE OF BIRTH April 1, 1878	9. AGE (In years) (last birthday) 77	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HRS. Hours _____ Min. _____
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Domestic	11. BIRTHPLACE (City and State or Foreign Country) Christian County Missouri		12. CITIZEN OF WHAT COUNTRY? U.S.A.
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13a. FATHER'S NAME Jake Hicks		13b. MOTHER'S MAIDEN NAME Harrett Stephenson		14. NAME OF HUSBAND OR WIFE William Hicks	
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No.		16. SOCIAL SECURITY NO. None.	17. INFORMANT'S SIGNATURE OR NAME ADDRESS Mrs. Edgar Hicks, Sleeper, Mo.		
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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, asthenia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION 1. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Carcinoma of Pancreas & Metastases			INTERVAL BETWEEN ONSET AND DEATH ? 23 yrs
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Cachexia DUE TO (c) Cong. Heart Failure			
	II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. 157X			

19a. DATE OF OPERATION -	19b. MAJOR FINDINGS OF OPERATION Open. on a Springfield found CP of Pancreas & Metastases		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)
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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? Jan 29
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22. I hereby certify that I attended the deceased from **228**, 1956, to **Feb 3**, 1956, that I last saw the deceased alive on **Feb 3**, 1956, and that death occurred at **6:00P** m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) George R. Necker M.D.		23b. ADDRESS Johnson Mo	23c. DATE SIGNED 2-9-56
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24a. BURIAL, CREMATION, REMOVAL	24b. DATE 2-5-56	24c. NAME OF CEMETERY OR CREMATORY Jones Cemetery	24d. LOCATION (City, town, or county) (State) Christian County Mo.
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DATE REC'D BY LOCAL REG. 2-4-1956	REGISTRAR'S SIGNATURE Hella L. Hlayo	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Everett J. Cheatham Galena, Mo.
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

Received 2-11-56
Laclede County Health Unit
File No. 17
Date Filed 2-11-56

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 Stanley R Palmer

Licensed Embalmer No. 4814
P. O. Address Lebanon,

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.