

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **9135**
Registrar's No. **1090**

BIRTH NO. **23931-56** REG. DIST. NO. **149** PRIMARY REG. DIST. NO. **1002**

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 OR TOWN Kansas City	c. LENGTH OF STAY (In this place) 10 days	c. CITY OR TOWN Kansas City	d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
d. FULL NAME OF HOSPITAL OR INSTITUTION St. Joseph Hospital		e. STREET ADDRESS (If rural, give location) 5117 Forest 3158	

3. NAME OF DECEASED (Type or Print) a. (First) Infant b. (Middle) Hicks c. (Last) Hicks			4. DATE OF DEATH (Month) (Day) (Year) 3 11 1956		
5. SEX Female		6. COLOR OR RACE White		7. MARRIED (NEVER MARRIED) <input type="checkbox"/> WIDOWED, DIVORCED (Specify) -	
8. DATE OF BIRTH 3/11/56		9. AGE (In years last birthday) 10		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) -	
10a. USUAL OCCUPATION		10b. KIND OF BUSINESS OR INDUSTRY -		11. BIRTHPLACE (City and State or Foreign Country) Kansas City, Missouri	
12. CITIZEN OF WHAT COUNTRY? U.S.		13a. FATHER'S NAME Audley Ross Hicks		13b. MOTHER'S MAIDEN NAME Bette Ann McGraw Hicks	
14. NAME OF HUSBAND OR WIFE -		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) -		16. SOCIAL SECURITY NO. None	
17. INFORMANT'S SIGNATURE OR NAME Bette Ann McGraw Hicks		18. ADDRESS -		19. MEDICAL CERTIFICATION	

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.		I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Premature rupture of membranes at 23 weeks.		INTERVAL BETWEEN ONSET AND DEATH 10 days	
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		DUE TO (b) Atelutasis			
DUE TO (c) -					

19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
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) (Min.)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from **3-11**, 19**56**, to **3-11**, 19**56**, that I last saw the deceased alive on **3-11**, 19**56**, and that death occurred at **5:00** a.m., from the causes and on the date stated above.

23a. SIGNATURE A. B. Sinclair, Jr. (Degree or title) MD		23b. ADDRESS 940 W. 47th		23c. DATE SIGNED 3-12-56	
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE 3-12-56		24c. NAME OF CEMETERY OR CREMATORY Calvary	
24d. LOCATION (City, town, or county) (State) Kansas City Missouri		25. FUNERAL DIRECTOR'S SIGNATURE Melody-McGilley-Eylar		ADDRESS 1800 E. Linwood	
DATE REC'D BY LOCAL REG. 3-12-56		REGISTRAR'S SIGNATURE Neva Marshall			

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.....
Signature of Student Embalmer

Signed *Ivan E. Miller*

Licensed Embalmer No. *498*

P. O. Address *R. C. M.*

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.