

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATHState File No. **7982**

FILED APR 10 1957

1377

|  |  |  |  |  |   |   |  |   |  |
|--|--|--|--|--|---|---|--|---|--|
| BIRTH NO. _____  |  | REG. DIST. NO. <b>393</b>  |  | PRIMARY REG. DIST. NO. <b>1002</b>   |   | Registrar's No. <b>1377</b>   |  |   |  |
| 1. PLACE OF DEATH<br>a. COUNTY <b>Clay</b>   |  |  |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).<br>a. STATE <b>Mo</b> |   |   |  | b. COUNTY <b>Clay</b>   |  |
| b. CITY (If outside corporate limits, write RURAL and give town)<br><b>K.C. North</b>  |  | c. LENGTH OF STAY (in this place)<br><b>Life</b>   |  | c. CITY OR TOWN<br><b>K.C. North</b>   |   | d. Is Residence within limits of a city or incorporated town?<br>Yes <input type="checkbox"/> No <input type="checkbox"/> |  |   |  |
| d. FULL NAME OF HOSPITAL OR INSTITUTION<br><b>3930 N Bales</b>   |  |  |  | e. STREET ADDRESS (If rural, give location)<br><b>5078 3930 N Bales</b>                                      |   |   |  |   |  |
| 3. NAME OF DECEASED<br>(Type or Print)<br><b>CHRISTINA ANNE</b>  |  | a. (First)   |  | b. (Middle)<br><b>HICKS</b>  |   | c. (Last)   |  | 4. DATE OF DEATH<br>(Month) (Day) (Year)<br><b>3/24/57</b>                          |  |
| 5. SEX<br><b>F</b>   |  | 6. COLOR OR RACE<br><b>W</b>   |  | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)<br><b>never married</b>                               |   | 8. DATE OF BIRTH<br><b>AUG 1 - 1953</b>   |  | 9. AGE (In years last birthday) IF UNDER 1 YEAR: Months Days Hours Min.<br><b>3</b> |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)  |  |  |  | 10b. KIND OF BUSINESS OR INDUSTRY  |   | 11. BIRTHPLACE (City and State or Foreign Country)<br><b>Kansas City, Mo.</b>   |  | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.</b>   |  |
| 13a. FATHER'S NAME<br><b>Carroll Hicks</b>   |  |  | 13b. MOTHER'S MAIDEN NAME<br><b>Lorane Casey</b> |  |   | 14. NAME OF HUSBAND OR WIFE   |  |   |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)   |  |  | 16. SOCIAL SECURITY NO.                          |  | 17. INFORMANT'S SIGNATURE OR NAME ADDRESS<br><b>Carroll Hicks of Home</b> |   |  |   |  |
| 18. CAUSE OF DEATH<br>Enter only one cause per line for (a), (b), and (c)<br><br>*This does not mean the mode of dying, such as heart failure, arteria, etc. It means the disease, injury, or complication which caused death.                               |  | MEDICAL CERTIFICATION<br>I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Acute lymphatic leukemia</b>  |  |  |   |   |  | INTERVAL BETWEEN ONSET AND DEATH<br><b>Months</b>                                   |  |
|  |  | ANTECEDENT CAUSES<br>Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.<br>DUE TO (b) <b>Cause unknown</b> |  |  |   |   |  |   |  |
|  |  | DUE TO (c)   |  |  |   |   |  |   |  |
|  |  | II. OTHER SIGNIFICANT CONDITIONS<br>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? <b>2</b><br>YES <input type="checkbox"/> NO <input 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)  |  | 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 <b>1956</b> , 19 <b>Aug 24 1957</b> , that I last saw the deceased alive on <b>3-24-57</b> , 19 <b>57</b> , and that death occurred at <b>2 a. m.</b> , from the causes and on the date stated above. |  |  |  |  |   |   |  |   |  |
| 23a. SIGNATURE<br><b>Bernard L. Mullins</b> (Degree or title)  |  |  |  | 23b. ADDRESS<br><b>1806 S. W. 11th St. K.C. Mo.</b>  |   | 23c. DATE SIGNED<br><b>3-24-57</b>  |  |   |  |
| 24a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Removal</b>  |  | 24b. DATE<br><b>3/24/57</b>  |  | 24c. NAME OF CEMETERY OR CREMATORY<br><b>Spring Creek Cem</b>  |   | 24d. LOCATION (City, town, or county) (State)<br><b>Calico Rock Ark.</b>  |  |   |  |
| DATE REC'D BY LOCAL REG.<br><b>3-24-57</b>   |  | REGISTRAR'S SIGNATURE<br><b>neva minshall</b>  |  | 25. FUNERAL DIRECTOR'S SIGNATURE<br><b>D.W. Newcomer's Sons</b>  |   | ADDRESS<br><b>2 K.C. Mo.</b>  |  |   |  |

(Licensed Embalmer's Statement on Reverse Side)

WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD  
Bernard L. Mullins

**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... *Shawn H. Hill* .....

Licensed Embalmer No... *458* .....

P. O. Address... *K.C. 16, 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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.  
If this body is not embalmed, fact should be so stated above.

