Health, & Welfare Public Service

S. 300 / 1-57

FILED NOV 4 1957

THE DIVISION OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

35446
STATE FILE NUMBER

Registration District No. 128 Primary Registration District No. 2000 Registrar's No. 1046-A

1. PLACE OF DEATH
a. COUNTY Greene
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Springfield — Inside Limits Yes X No
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 622 S.Pickwick — Length of stay in 1b 33 Yrs.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Missouri b. COUNTY GREENE
c. CITY OR TOWN Springfield 0396 — Inside Limits Yes XX No
d. STREET ADDRESS (If outside, give location) 622 S. Pickwick — Reside on Farm Yes No X

3. NAME OF DECEASED (Type or print) First CLEVELAND Middle P. Last HICKS
4. DATE OF DEATH Month October Day 26 Year 1957
5. SEX Male
6. COLOR OR RACE White
7. MARRIED X NEVER MARRIED WIDOWED DIVORCED
8. DATE OF BIRTH 5 August 1884
9. AGE (In years last birthday) 73 — 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) Insurance Agent
10b. KIND OF BUSINESS OR INDUSTRY Insurance
11. BIRTHPLACE (City and state or country) Tennessee
12. CITIZEN OF WHAT COUNTRY? USA
13a. FATHER'S NAME B.N. Hicks
13b. MOTHER'S MAIDEN NAME Unknown
14. NAME OF HUSBAND OR WIFE Hazel Hicks
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. Unknown
17. INFORMANT Hazel Hicks Address Springfield, Mo.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Coronary occlusion, acute — INTERVAL BETWEEN ONSET AND DEATH Few secs.
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b)
DUE TO (c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) 4201
19. WAS AUTOPSY PERFORMED? YES NO X
20a. ACCIDENT SUICIDE HOMICIDE
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year
20d. INJURY OCCURRED WHILE AT WORK NOT WHILE AT WORK
20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
20f. CITY, TOWN, OR LOCATION COUNTY STATE
21. I attended the deceased from June '57 to 10-26-57 and last saw him alive on Sept. 19, '57
Death occurred at 4:20 P.M. on the date stated above; and to the best of my knowledge, from the causes stated.
22a. SIGNATURE G B Lemmon MD (Degree or Title)
22b. ADDRESS 609 Cherry Springfield, Missouri
22c. DATE SIGNED 10-28-57
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial
23b. DATE 10-29-57
23c. NAME OF CEMETERY OR CREMATORY Maple Park
23d. LOCATION (City, town, or county) (State) Springfield, Missouri
24. FUNERAL DIRECTOR J.W. Clingner Co. ADDRESS Spgfd. Mo.
25. DATE RECD. BY LOCAL REG. 11-1-57
26. REGISTRAR'S SIGNATURE Edna Williamson

(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related.

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 ..... Signed .....
Signature of Student Embalmer

Licensed Embalmer No. 4071

P. O. Address .....

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.