

pt. Health,
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S. Public
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V. S. 300
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THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

40548
STATE FILE NUMBER

FILED DEC 5- 1957

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 5407

1. PLACE OF DEATH a. COUNTY <u>Jackson</u>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Jackson</u>		
b. CITY (If outside corporate limits, give TOWNSHIP only) <u>Kansas City</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>Kansas City</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>5959 E. 13th</u>		Length of stay in 1b <u>15 months</u>	d. STREET ADDRESS (If outside, give location) <u>5959 E. 13th St.</u>		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last <u>WILLIAM HENRY PICKERELL</u>			4. DATE OF DEATH Month Day Year <u>Nov 14 1957</u>		
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>January 24 1869</u>	9. AGE (In years last birthday)	IF UNDER 1 YEAR: Months Days Hours Min. <u>18</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Dealer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Hardware</u>	11. BIRTHPLACE (City and state or country) <u>Marion Co. Iowa U.S.A</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>
13a. FATHER'S NAME <u>Josiah Pickerell</u>		13b. MOTHER'S MAIDEN NAME <u>Matilda Keyes</u>		14. NAME OF HUSBAND OR WIFE <u>Lara Pickerell</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT Address <u>Dr. A. S. Pickerell - 5959 E. 13th - 6 mo</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Peripheral Circulatory Collapse</u>					INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>General inanition</u>					<u>3 mo.</u>
DUE TO (c) <u>apoplexy</u>					<u>334+</u> <u>4 mo.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)		
20c. TIME OF INJURY Hour Month, Day, Year a.m. p.m.					
20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		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 <u>April 1957</u> to <u>Nov. 14 1957</u> and last saw ^{him} <u>Nov. 8, 1957</u> Death occurred at <u>6:10</u> A m on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE <u>Glenn W. Springer D.O.</u>			22b. ADDRESS <u>5902 St. John Ave. Kansas City, Mo.</u>		22c. DATE SIGNED <u>11-14-57</u>
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE	23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town, or county) (State)
<u>Removal</u>		<u>Nov. 15 1957</u>	<u>Highland Cemetery</u>		<u>Eddyville, Iowa</u>
24. FUNERAL DIRECTOR ADDRESS <u>Hills Funeral Home 2315 Lenox</u>			25. DATE RECD. BY LOCAL REG. <u>11-15-57</u>	26. REGISTRAR'S SIGNATURE <u>New Minshall</u>	

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.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE
MEDICAL CERTIFICATION
Glenn W. Springer



310361044

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 *Chas E. Wilks*

Licensed Embalmer No. *2644*

P. O. Address *MEMO*

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.