

Health,  
Welfare  
Public  
Service

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

58-005362  
STATE FILE NUMBER

FILED MAR 10 1958

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 893

00  
57

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>Dallas</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Kansas City</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>BUFFALO</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>Gen'l Hosp. #1</u>		Length of stay in lb <u>9 mos.</u>	d. STREET ADDRESS (If outside, give location) <u>XXXXXX Garden XXX</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print)	First <u>Guy</u>	Middle <u>C.</u>	Last <u>Bickett</u>	4. DATE OF DEATH	Month <u>2</u>	Day <u>17</u>	Year <u>1958</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>Feb. 12, 1880</u>	9. AGE (In years last birthday) <u>78</u>	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours	Min.
-----------------------	----------------------------------	---	--	--	---------------------------	--------------------------	-------	------

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Salesman</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>MISC.</u>	11. BIRTHPLACE (City and state or country) <u>Maryville, Missouri</u>	12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
--	---	--	--

13a. FATHER'S NAME <u>J. H. Bickett</u>	13b. MOTHER'S MAIDEN NAME <u>Emma McClure</u>	14. NAME OF HUSBAND OR WIFE <u>Winona Bickett</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>495-09-2448</u>	17. INFORMANT <u>EARL BICKETT</u> Address <u>Gashland, Mo. Box 40</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>Hematuria</u>		INTERVAL BETWEEN ONSET AND DEATH <u>1201</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <u>myocardial infarction</u>	
	DUE TO (c) _____	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Malnutrition and dehydration</u>		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 _____ a.m. _____ p.m. _____	20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> WORK <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>Feb. 14, 1958</u> to <u>Feb. 17, 1958</u> and last saw <u>him</u> alive on <u>Feb. 17, 1958</u> Death occurred at <u>9:25 P.</u> m on the date stated above; and to the best of my knowledge, from the causes stated.
--

22a. SIGNATURE <u>R. S. Brown, M.D.</u> (Degree or title)	22b. ADDRESS <u>24th &amp; Cherry</u>	22c. DATE SIGNED <u>2-18-58</u>
--	--	------------------------------------

23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	23b. DATE <u>2-18-58</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Hilderbrand</u>	23d. LOCATION (City, town, or county) (State) <u>Buffalo Mo</u>
---	-----------------------------	--	--

25. DATE RECD. BY LOCAL REG. <u>2-19-58</u>	26. REGISTRAR'S SIGNATURE <u>neva marshall</u>
--	---

(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

B. I. BIRTHS

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 .....  
Signature of Student Embalmer

Signed *John R. [Signature]*

Licensed Embalmer No. *453*

P. O. Address *Kansas City*

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.