

Dr. PURCELL

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

59-009061  
STATE FILE NUMBER

FILED APR 6 1959 Registration District No. 128 Primary Registration District No. 2000 Registrar's No. 343

1. PLACE OF DEATH a. COUNTY <b>GREENE</b>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>KANSAS</b> b. COUNTY <b>WYANDOTTE</b>		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>SPRINGFIELD</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <b>KANSAS CITY</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>MERCY HOSP.</b>		Length of stay in 1b	d. STREET ADDRESS (If outside, give location) <b>5412 NEOSHO</b>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>RICHARD</b> Middle <b>M.</b> Last <b>HICKEY</b>			4. DATE OF DEATH Month <b>MARCH</b> Day <b>29</b> Year <b>1959</b>		
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>JAN. 25 1885</b>	9. AGE (In years birthday) <b>74</b>	FUNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>RETIRED POSTAL MAIL</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>CLERK</b>	11. BIRTHPLACE (City and state or country) <b>PLATTSBURG, MISSOURI</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>
13a. FATHER'S NAME <b>MICHAEL J. HICKEY</b>		13b. MOTHER'S MAIDEN NAME <b>MARY POLLARD</b>		14. NAME OF HUSBAND OR WIFE <b>BERTHA HICKEY (DEC.)</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>?</b>	17. INFORMANT Address <b>THERESA HICKEY KANSAS CITY, KAN.</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>arteriosclerotic heart disease</b>					INTERVAL BETWEEN ONSET AND DEATH <b>19 yr.</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) _____ DUE TO (c) _____					<b>4200</b>
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 _____ a.m. _____ p.m.					
20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE 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 <b>1-19-59</b> to <b>3-29-59</b> and last saw <sup>him</sup> alive on <b>3-27-59</b> Death occurred at <b>3:20 a.m.</b> m on the date stated above, and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE <i>Elmer M Purcell</i> (Degree or title)			22b. ADDRESS <b>M.D. 609 Cherry-Springfield, Mo.</b>		22c. DATE SIGNED <b>3-30-59</b>
23a. BURIAL, CREMATION, or other disposition (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town, or county) (State)	
<b>BURIAL</b>	<b>3/31/59</b>	<b>OSCEOLA, CEMETERY</b>		<b>OSCEOLA, MISSOURI</b>	
24. FUNERAL DIRECTOR <b>H. H. LOHMEYER</b>		ADDRESS <b>S'RINGFIELD, MO.</b>		25. DATE RECD. BY LOCAL REG. <b>4-1-59</b>	26. REGISTRAR'S SIGNATURE <i>Officer E. Melton</i>

(Licensed Embalmer's Statement on Reverse Side)

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

15 1959

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 *Jane C. Hunter*

Licensed Embalmer No. *4739*

P. O. Address *Spokane, 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.