

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-016414

STATE FILE NUMBER

FILED MAY 5 1959 Registration District No. 323 Primary Registration District No. 4474 Registrar's No. 17

1. PLACE OF DEATH a. COUNTY <i>Saline</i>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Missouri</i> b. COUNTY <i>Saline</i>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <i>Sweet Springs</i>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <i>Sweet Springs</i> 0970 Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <i>Large Rest Home</i>		Length of stay in lb <i>3 yrs</i>	d. STREET ADDRESS (If outside, give location) <i>105 Reavis</i>
Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			

3. NAME OF DECEASED (Type or print) First <i>Sarah</i> Middle <i>Margaret</i> Last <i>Hicks</i>			4. DATE OF DEATH Month <i>April</i> Day <i>29</i> Year <i>1959</i>			
5. SEX <i>Female</i>	6. COLOR OR RACE <i>white</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <i>WIDOWED</i> <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>July 20, 1863</i>	9. AGE (In years last birthday) <i>95</i>	IF UNDER 1 YEAR Months <i>0</i> Days <i>0</i>	IF UNDER 2 HRS. Hours <i>0</i> Min. <i>0</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Home</i>	11. BIRTHPLACE (City and state or country) <i>Saline Co. Mo.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	

13a. FATHER'S NAME <i>Pleasant Dickerson</i>		13b. MOTHER'S MAIDEN NAME <i>Ann Lockrey</i>		14. NAME OF HUSBAND OR WIFE <i>Wm Robert Hicks</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <i>no</i>		16. SOCIAL SECURITY NO. <i>none</i>	17. INFORMANT Address <i>Mrs. W.F. Hicks, Fort Worth, Texas</i>		

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Hypostatic Pneumonia</i>			INTERVAL BETWEEN ONSET AND DEATH <i>3 days</i> <i>20 yrs</i>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.		DUE TO (b) <i>Smiley</i>	
		DUE TO (c)	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <i>522X</i>			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 <i>10:20</i> Month, Day, Year <i>1959</i> a.m. p.m.			

20d. INJURY OCCURRED WHILE AT 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 <i>Sweet Springs, Mo.</i>	COUNTY	STATE
21. I attended the deceased from <i>1953</i> to <i>1959</i> and last saw her alive on <i>4-29-59</i> Death occurred at <i>10:20</i> pm on the date stated above; and to the best of my knowledge, from the causes stated.		22a. SIGNATURE (Deceased or mine) <i>Charles A. Worley, M.D.</i>		22b. ADDRESS <i>Sweet Springs, Mo.</i>
22c. DATE SIGNED <i>5-1-59</i>				

23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	23b. DATE <i>May 1, 1959</i>	23c. NAME OF CEMETERY OR CREMATORY <i>Fairview Cemetery</i>	23d. LOCATION (City, town, or county) <i>Sweet Springs, Mo.</i>	(State)
24. FUNERAL DIRECTOR <i>E. L. Moseley, Sweet Springs, Mo.</i>	25. DATE RECD. BY LOCAL REG. <i>May 1, 1959</i>	26. REGISTRAR'S SIGNATURE <i>Mary Worley</i>		

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

Charles A. Worley, M.D.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

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 *Edgar L Moseley*

Licensed Embalmer No. *4710*

P. O. Address *Sweet Spring*

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.