

UNIFORM DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS OCT 23 1959

59-036212

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 4863 STATE FILE NUMBER

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) OR TOWN <u>KANSAS CITY</u>		c. CITY OR TOWN <u>KANSAS CITY</u>	
Length of stay in 1b <u>72 YRS</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>St. Lukes Hospital</u>		d. STREET ADDRESS (If outside, give location) <u>4112 GENESEE</u>	
Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First Middle Last <u>LEO MICHAEL HICKEY</u>			4. DATE OF DEATH Month Day Year <u>OCTOBER 8-1959</u>		
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>R-9-1883</u>	9. AGE (last birthday) <u>76</u>	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Plumber</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>A.D. JACOBSON & Co. Plumbing</u>		11. BIRTHPLACE (City and state or country) <u>Independence Mo</u>	
12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>					

13a. FATHER'S NAME <u>John Hickey</u>		13b. MOTHER'S MAIDEN NAME <u>MARY ANN LARKIN</u>		14. NAME OF HUSBAND OR WIFE <u>MINNIE HICKEY</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>WIFE MINNIE HICKEY 4112 GENESEE R.C. Mo</u>	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:			INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a) <u>UREMIA</u>			<u>3 MOS</u>
DUE TO (b) <u>POLYCYSTIC KIDNEYS</u>			<u>CONGENITAL?</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>Hypertensive Heart Disease</u>			PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown

19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input 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.)
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20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year	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 COUNTY STATE
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21. I attended the deceased from July 1959 to 10/8/59 and last saw him alive on 10/8/59
Death occurred at 9:29 A m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) <u>Wallace P. McKee M.D.</u>		22b. ADDRESS <u>315 Nichols Rd; KC, Mo</u>		22c. DATE SIGNED <u>10/9/59</u>
23a. METHOD OF CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>Oct 10-1959</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Woodlawn (St. Marys) Section</u>	23d. LOCATION (City, town, or county) (State) <u>Independence Missouri</u>	
24. FUNERAL DIRECTOR <u>States Funeral Home</u>	ADDRESS <u>412 1/2 State Line Kansas City, Kan</u>	25. DATE RECD. BY LOCAL REG. <u>10-9-59</u>	26. REGISTRAR'S SIGNATURE <u>Wesley Minshall</u>	

DOCUMENT

BY AFFIDAVIT OF WALLACE P. MCKEE 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

Murray Wilson

Licensed Embalmer No. 4989

P. O. Address Rockville

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.