

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

**59-039133**

STATE FILE NUMBER  
**33**

Health,  
Welfare  
Public  
Service

300  
1-57

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

1-0

**FILED VS NOV 3 0 1959**

Registration District No. 46 Primary Registration District No. 4066 Registrar's No. 33

|  |  |   |   |
|--|--|---|---|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Caldwell</u>   |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <u>mo</u> b. COUNTY <u>Caldwell</u>                       |   |
| b. CITY (If outside corporate limits, give TOWNSHIP only)<br>OR<br>TOWN <u>Kingston</u>  |  | Inside Limits<br>Yes <input type="checkbox"/> No <input type="checkbox"/>   | c. CITY OR TOWN <u>Polo</u>   |
| c. FULL NAME OF (If NOT in hospital, give location)<br>HOSPITAL OR INSTITUTION <u>Berry Best Home.</u>   |  | Length of stay in 1b<br><u>0130</u>   | d. STREET ADDRESS (If outside, give location)<br><u>C</u>   |
| 3. NAME OF DECEASED (Type or print)<br>first Middle Last<br><u>James A. Hicks</u>  |  | 4. DATE OF DEATH<br>Month Day Year<br><u>11-17-1959</u>   |   |
| 5. SEX<br><u>M.</u>  | 6. COLOR OR RACE<br><u>Wh.</u>   | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><u>Aug 5, 1873</u>  |
| 9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>Retired farmer</u>  |  | 9b. KIND OF BUSINESS OR INDUSTRY  | 9c. AGE (In years last birthday)<br><u>86</u>   |
| 10a. FATHER'S NAME<br><u>David Hicks</u>   |  | 10b. MOTHER'S MAIDEN NAME<br><u>Cindy Lester</u>  | 10c. CITIZEN OF WHAT COUNTRY?<br><u>Wayne Co. K. Y.</u>   |
| 11. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)  |  | 12. SOCIAL SECURITY NO.<br><u>X</u>   | 13. INFORMANT<br><u>Mrs. Florence Burns Polo Mo.</u>  |
| 14. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Lupus erythematosus disseminated</u>   |  |   | INTERVAL BETWEEN ONSET AND DEATH<br><u>5 years</u>  |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.<br>DUE TO (b) _____<br>DUE TO (c) _____   |  |   |   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)<br><u>456x</u>   |  |   | 19. WAS AUTOPSY PERFORMED?<br>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<br>Hour Month, Day, Year<br>a.m.<br>p.m.   |  |   |   |
| 20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE WORK <input type="checkbox"/> 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<br><u>Kingston Caldwell MO.</u>  | COUNTY STATE  |
| 21. I attended the deceased from <u>1956</u> to <u>11-17-59</u> and last saw her alive on <u>11-17-59</u><br>Death occurred at <u>10:20</u> m on the date stated above; and to the best of my knowledge, from the causes stated. |  |   |   |
| 22a. SIGNATURE<br><u>Frank R. Daley MD</u>   |  | 22b. ADDRESS<br><u>Hamleton, Mo.</u>  | 22c. DATE SIGNED<br><u>11-19-59</u>   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><u>Burial</u>   | 23b. DATE<br><u>11-19-1959</u>   | 23c. NAME OF CEMETERY OR CREMATORY<br><u>Mirabil Cemetery</u>   | 23d. LOCATION (City, town, or county) (State)<br><u>Mirabil Caldwell Co. Mo</u>                   |
| 24. FUNERAL DIRECTOR<br><u>Alspaugh &amp; Cowley Polo Mo</u>   |  | 25. DATE RECD. BY LOCAL REG.<br><u>Nov 24-59</u>  | 26. REGISTRAR'S SIGNATURE<br><u>Gladys Jones</u>  |

(Licensed Embalmer's Statement on Reverse Side)

*Fact.*

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.

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 *E. L. Howard* .....

Licensed Embalmer No. *4924* .....  
P. O. Address... *Pala, 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.