

MURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

'59 0 4 4 0 9 2

FILED VS DEC 3 0 1959

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 5945 STATE FILE NUMBER

UNRECORDED

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) <u>Kansas City</u>		Length of stay in 1b <u>3 yrs.</u>		c. CITY OR TOWN <u>Kansas City</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>Benton Nursing Home</u>				Institution Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <u>4025 Marell</u>	
3. NAME OF DECEASED (Type or print) First <u>John</u> Middle <u>Thomas</u> Last <u>Bicknell</u>				4. DATE OF DEATH Month <u>12</u> Day <u>7</u> Year <u>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>10-10-1870</u>	
9. AGE (last birthday) <u>89</u>		IF UNDER 1 YEAR Months <u>—</u> Days <u>—</u>		IF UNDER 24 HR Hours <u>—</u> Min. <u>—</u>		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>Book</u>		11. BIRTHPLACE (City and state or country) <u>Barsons, Kansas</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>			
13a. FATHER'S NAME <u>Alfred Bicknell</u>			13b. MOTHER'S MAIDEN NAME <u>Ellen —</u>			14. NAME OF HUSBAND OR WIFE <u>Myrtle Bicknell</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>498-30-0119</u>		17. INFORMANT <u>Mr. Myrtle Bicknell K.C.Mo.</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>Arteriosclerosis</u> DUE TO (b) <u>Arteriosclerosis</u> DUE TO (c) <u>Arteriosclerosis</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.						INTERVAL BETWEEN ONSET AND DEATH <u>8 years</u> <u>8 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)						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 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.)			
20c. TIME OF INJURY Hour <u>—</u> a.m. <u>—</u> p.m. <u>—</u> 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	
21. I attended the deceased from <u>11-1-59</u> to <u>12-7-59</u> and last saw her/him alive on <u>12-7-59</u> Death occurred at <u>5 pm</u> on the date stated above, and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE (Degree or title) <u>Paul Lawrence M.D.</u>				22b. ADDRESS <u>428 S. White Ave</u>		22c. DATE SIGNED <u>12-7-59</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>12-10-1959</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Washington Cem.</u>		23d. LOCATION (City, town, or county) (State) <u>Kansas City, Mo.</u>	
24. FUNERAL DIRECTOR <u>C.H. Blackman & Son Inc. K.C. Mo.</u>				25. DATE RECD. BY LOCAL REG. <u>12-10-59</u>		26. REGISTRAR'S SIGNATURE <u>Irene Minshall</u>	

DOCUMENT

BY AFFIDAVIT OF PAUL LAWRENCE, M.D. 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 Wayne Smith

Licensed Embalmer No. 5081

P. O. Address K. C. 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.