

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-002487

FILED VS JAN 25 1960

Registration District No. 207 Primary Registration District No. _____ Registrar's No. 6

STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY <u>Maries</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Maries</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) <u>Belle</u>		Length of stay in 1b <u>40 yrs</u>	c. CITY OR TOWN <u>Belle</u>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>At home</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>Louis</u> Middle <u>Harrison</u> Last <u>Hicks</u>			4. DATE OF DEATH Month <u>January</u> Day <u>19</u> Year <u>1960</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>Feb 16 - 1895</u>
9. AGE (last birthday) <u>84</u>		IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HR Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Public works</u>	11. BIRTHPLACE (City and state or country) <u>Texas County - Mo</u>
12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY	
12a. FATHER'S NAME <u>Pete Hicks</u>		12b. MOTHER'S MAIDEN NAME <u>Sarah Light</u>	12c. NAME OF HUSBAND OR WIFE <u>Martha Hicks</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 <u>Clarence Hicks - Belle - 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>Coronary occlusion</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Chronic Hypertension</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) 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			INTERVAL BETWEEN ONSET AND DEATH <u>10 min</u> <u>5 yrs</u>
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. _____ Month, Day, Year _____		20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" 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>1956</u> to <u>1/19/60</u> and last saw him alive on <u>1/18/60</u> Death occurred at <u>9:20</u> p.m. on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <u>R.A. Schouhah</u>		22b. ADDRESS <u>Belle Mo 1/20/60</u>	22c. DATE SIGNED <u>1/20/60</u>
23. BURIAL, CREMATION, REMOVAL (Specify) <u>Buried</u>	23b. DATE <u>Jan 22 - 1960</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Liberty Cemetery</u>	23d. LOCATION (City, town, or county) (State) <u>Belle - Missouri</u>
25. DATE RECD. BY LOCAL REG. <u>1-22-60</u>		26. REGISTRAR'S SIGNATURE <u>Wynell Hutcherson</u>	

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by _____ or by _____, Student Embalmer No. _____ working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed Charles Sisson

Licensed Embalmer No. 4178

P. O. Address Blender

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.