

**MURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH**

**60-010261**

**FILED VS. APR. 14 1960 70**

STATE FILE NUMBER

RECEIVED

Primary Registration District No. Registrar's No. **30**

<b>1. PLACE OF DEATH</b> a. COUNTY <b>CLARK</b> b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>KAHOKA</b> Length of stay in 1b <b>6 weeks</b> c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>MITCHELL NURSING HOME</b> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <b>MO.</b> b. COUNTY <b>CLARK</b> c. CITY OR TOWN <b>KAHOKA</b> 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"/>			
<b>3. NAME OF DECEASED</b> (Type or print) First Middle Last <b>JAMES DAVIS HICKS</b>			<b>4. DATE OF DEATH</b> Month Day Year <b>MARCH 27 1960</b>				
<b>5. SEX</b> <b>MALE</b>	<b>6. COLOR OR RACE</b> <b>WHITE</b>	<b>7. Married</b> <input type="checkbox"/> <b>Never Married</b> <input type="checkbox"/> <b>Widowed</b> <input checked="" type="checkbox"/> <b>Divorced</b> <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <b>JUNE 12, 1878</b>	<b>9. AGE (last birthday)</b> <b>81</b>	<b>IF UNDER 1 YEAR</b> Months <b>9</b> Days <b>25</b>	<b>IF UNDER 24 HR</b> Hours <b>0</b> Min. <b>0</b>	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Farming</b>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b>		<b>11. BIRTHPLACE</b> (City and state or country) <b>Scotland Co. Mo.</b>	<b>12. CITIZEN OF WHAT COUNTRY</b> <b>U.S.</b>		
<b>13a. FATHER'S NAME</b> <b>A.N. HICKS</b>		<b>13b. MOTHER'S MAIDEN NAME</b> <b>ELIZABETH SHACKLETT</b>		<b>14. NAME OF HUSBAND OR WIFE</b> <b>ANNA HICKS</b>			
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes, give war or dates of service)		<b>16. SOCIAL SECURITY NO.</b> <b>486-42-0669</b>	<b>17. INFORMANT</b> Address <b>MRS GEORGE MARTIN, WYACONDA, MO</b>				
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Profound secondary anemia</b> DUE TO (b) <b>Infiltration of bone marrow</b> DUE TO (c) <b>Hodgkins disease</b> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.					INTERVAL BETWEEN ONSET AND DEATH <b>3 weeks</b> <b>Unknown</b> <b>Unknown</b>		
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		
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	<b>20a. ACCIDENT</b> <input type="checkbox"/> <b>SUICIDE</b> <input type="checkbox"/> <b>HOMICIDE</b> <input type="checkbox"/>	<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in PART I or PART II of item 18.)					
<b>20c. TIME OF INJURY</b> Hour a.m. p.m. Month, Day, Year		<b>20d. INJURY OCCURRED WHILE AT WORK</b> <input type="checkbox"/> <b>NOT WHILE AT WORK</b> <input type="checkbox"/>					
<b>20e. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.)		<b>20f. CITY, TOWN, OR LOCATION</b>		<b>COUNTY</b>	<b>STATE</b>		
<b>21. I attended the deceased from</b> <b>1-26-60</b> to <b>3-27-60</b> and last saw <sup>her</sup> <b>live on</b> <b>3-27-60</b> Death occurred at <b>8:30p.</b> m on the date stated above, and to the best of my knowledge, from the causes stated.							
<b>22a. SIGNATURE</b> (Degree or title) <b>R. W. Williams, M.D.</b>			<b>22b. ADDRESS</b> <b>Kahoka, Mo.</b>		<b>22c. DATE SIGNED</b> <b>4-8-60</b>		
<b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b> <b>Burial</b>	<b>23b. DATE</b> <b>March 30 1960</b>	<b>23c. NAME OF CEMETERY OR CREMATORY</b> <b>Wyaconda Cemetery</b>		<b>23d. LOCATION</b> (City, town, or county) (State) <b>Wyaconda, Mo.</b>			
<b>24. FUNERAL DIRECTOR</b> ADDRESS <b>GERTH &amp; BASKETT</b>		<b>25. DATE RECD. BY LOCAL REG.</b> <b>4-9-60</b>		<b>26. REGISTRARS SIGNATURE</b> <b>J. B. Bridger</b>			

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

(Licensed Embalmer's Statement on Reverse Side)

**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 George V Baake

Licensed Embalmer No. 1817

P. O. Address Wyacon

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to conform 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.