

IRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS JUN 6 1960

= 60-019974

INDEXED

Registration District No. 383 Primary Registration District No. 5655 Registrar's No. 41 STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY <u>Lawrence</u> b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Mt. Vernon</u> Length of stay in 1b <u>1 day</u> c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Mo. State Sanatorium</u> Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>Greene</u> c. CITY OR TOWN <u>Springfield</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> d. STREET ADDRESS (If outside, give location) <u>2731 W. College</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Willie</u> Middle <u>Lee</u> Last <u>Hicks</u>			4. DATE OF DEATH Month <u>May</u> Day <u>21</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>12-2-23</u>	9. AGE (last birthday) <u>36</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>Factory work -- Farming</u>		10b. KIND OF BUSINESS OR INDUSTRY <u> </u>		11. BIRTHPLACE (City and state or country) <u>Missouri</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>	
13a. FATHER'S NAME <u>William Towel</u>			13b. MOTHER'S MAIDEN NAME <u>Rada Hicks</u>		14. NAME OF HUSBAND OR WIFE <u>Mada 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>489-24-9273</u>		17. INFORMANT Address <u>San.records, Mo.State San.,Mt.Vernon,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>Multiple pulmonary abscess, bilateral, infecting organism unknown</u> DUE TO (b) <u> </u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (c) <u> </u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Pulmonary tuberculosis Far Advanced, probably active; lobular pneumonia, left; localized empyema left, infecting organism unknown.</u>					INTERVAL BETWEEN ONSET AND DEATH <u> </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.) <u> </u>			
20c. TIME OF INJURY Hour <u> </u> a.m. / p.m. Month, Day, Year <u> </u>		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.) <u> </u>			
		20f. CITY, TOWN, OR LOCATION <u> </u>		COUNTY <u> </u> STATE <u> </u>			
21. I attended the deceased from <u>5 - 20 - 60</u> , to <u>5 - 21 - 60</u> and last saw him alive on <u>5 - 21 - 60</u> Death occurred at <u>10:52 p.m.</u> on the date stated above, and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE (Degree or title) <u>J. Lewis Gale, M.D.</u>			22b. ADDRESS <u>Mt. Vernon, Missouri</u>		22c. DATE SIGNED <u>5-23-60</u>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		23b. DATE <u>5-22-60</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Maple Park</u>		23d. LOCATION (City, town, or county) (State) <u>Springfield, Mo.</u>		
24. FUNERAL DIRECTOR ADDRESS <u>Brim-Davis Funeral Service, Springfield, Mo.</u>		25. DATE RECD. BY LOCAL REG. <u>6-1-60</u>		26. REGISTRAR'S SIGNATURE <u>H. L. Fossitt</u>			

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

JUN 24 1960

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

Ray E. Ireland

Licensed Embalmer No. 5052

P. O. Address Belmont, Mass

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.