

FEDERAL DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH
FILED VS MAY 25 1960

-60-020277

Registration District No. 257 Primary Registration District No. 5880 Registrar's No. 32

STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY <u>OSAGE</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MO.</u> b. COUNTY <u>Chawford twp</u>									
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Linn, mo.</u>		Length of stay in 1b <u>2 Wks.</u>		c. CITY OR TOWN <u>Rural</u>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>							
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Linn Manor Rest Home</u>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS <u>(If outside, give location)</u>		Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>						
3. NAME OF DECEASED (Type or print) First <u>Soloman</u> Middle <u>L.</u> Last <u>Licklider</u>				4. DATE OF DEATH Month <u>May</u> Day <u>20</u> Year <u>60</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>4-13-1891</u>		9. AGE (last birthday) <u>89</u>		IF UNDER 1 YEAR Months <u>1</u> Days <u>7</u> Hours <u></u> Min. <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>Retired farmer</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>←</u>		11. BIRTHPLACE (City and state or country) <u>Chawford Co. MO.</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>						
13a. FATHER'S NAME <u>Chas. Licklioen</u>				13b. MOTHER'S MAIDEN NAME <u>Rebecca Wright</u>				14. NAME OF HUSBAND OR WIFE <u>Elizabeth Licklider</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>←</u>				16. SOCIAL SECURITY NO. <u>←</u>		17. INFORMANT <u>Elizabeth Licklider - R.R. Cuba, 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>Hypostatic pneumonia</u> DUE TO (b) <u>Cerebral Hemorrhage</u> DUE TO (c) <u>Arterio sclerosis, generalized</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Op. 460 Ca Colon ?</u>										INTERVAL BETWEEN ONSET AND DEATH			
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 <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>5-6-60</u> to <u>5-20-60</u> and last saw ^{her} him alive on <u>5-18-60</u> Death occurred at <u></u> on the date stated above, and to the best of my knowledge, from the causes stated.													
22a. SIGNATURE (Degree or title) <u>Soloman W. Baldwin DO</u>						22b. ADDRESS <u>Linn</u>			22c. DATE SIGNED <u>5-24-60</u>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>5-22-60</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Licklider Cem.</u>			23d. LOCATION (City, town, or county) (State) <u>Chawford Co. MO.</u>						
24. FUNERAL DIRECTOR <u>Oral E. Licklider - St. James, MO.</u>				25. DATE RECD. BY LOCAL REG. <u>5/24/60</u>		26. REGISTRAR'S SIGNATURE <u>Mrs. Clyde Maston</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 me, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed Oral E. Lickhal

Licensed Embalmer No. 354

P. O. Address St. James

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