

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-025226

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 3568 STATE FILE NUMBER

AMENDED

FILED AUG 8 1961

| | | | |
|--|---------------------------------------|---|---|
| 1. PLACE OF DEATH a. COUNTY Jackson | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo. b. COUNTY Jackson | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Kansas City | Length of stay in Tb 4 days | c. CITY OR TOWN Independence | Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/> |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION St. Lukes Hospital | | d. STREET ADDRESS (If outside, give location) 1210 S. Main | Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> |

| | | | | | |
|---|----------------------------------|---|--|-------------------------------------|---|
| 3. NAME OF DECEASED (Type or print) First Middle Last MRS. BESS HUGHES HICKERSON | | | 4. DATE OF DEATH Month Day Year July 17, 1961 | | |
| 5. SEX Female | 6. COLOR OR RACE White | 7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/> | 8. DATE OF BIRTH Aug. 17, 1886 | 9. AGE (last birthday) 74 | IF UNDER 1 YEAR Months Days Hours Min. |

| | | | |
|---|-----------------------------------|--|---|
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | 10b. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (City and state or country) Independence, Mo. | 12. CITIZEN OF WHAT COUNTRY USA |
|---|-----------------------------------|--|---|

| | | |
|--|--|--|
| 13a. FATHER'S NAME William J. Hughes | 13b. MOTHER'S MAIDEN NAME Flisky McClellen | 14. NAME OF HUSBAND OR WIFE Dr. J.C. Hickerson, dec. |
|--|--|--|

| | | |
|--|--|--|
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No | 16. SOCIAL SECURITY NO. None | 17. INFORMANT Dr. William Hickerson Address Independence, Mo. |
|--|--|--|

| | | | |
|--|-------------------------------------|--|----------------|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH CAUSED BY: IMMEDIATE CAUSE (a) Azotemia | | INTERVAL BETWEEN ONSET AND DEATH 36 hours | |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. | DUE TO (b) Sepsis | | 7 mos. |
| | DUE TO (c) Biliary Cirrhosis | | 1 year. |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) R. pleural effusion. | | 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 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 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 1-30-61 to 7-17-61 and last saw her/him alive on 7-17-61 . Death occurred at 3:40 p.m. on the date stated above, and to the best of my knowledge, from the causes stated: |
|---|

| | | |
|--|---|------------------------------------|
| 22a. SIGNATURE P. Byers M.D. (Degree or title) | 22b. ADDRESS 4635 Wyandotte, K.C. 12, Mo. | 22c. DATE SIGNED 7-18-61 |
|--|---|------------------------------------|

| | | | |
|--|-----------------------------------|--|---|
| 23a. MORTALITY CREMATION, REMOVAL (Specify) Burial | 23b. DATE July 19, 1961 | 23c. NAME OF CEMETERY OR CREMATORY Woodlawn Cemetery | 23d. LOCATION (City, town, or county) (State) Independence, Mo. |
|--|-----------------------------------|--|---|

| | | |
|--|--|---|
| 24. FUNERAL DIRECTOR OTT & MITCHELL, Indep., Mo. | 25. DATE RECD. BY LOCAL REG. 7-18-61 | 26. REGISTRAR'S SIGNATURE Ruth Long |
|--|--|---|

DATE AMENDED
 AMENDMENTS ON THIS RECORD ARE AS FOLLOWS
 INSTAED OF
 DOCUMENT
 MEDICAL CERTIFICATION
 BY AFFIDAVIT OF
 Byers
 ITEM NO. SHOULD READ

MAR 29 1962

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 Henry J. Mitchell

Licensed Embalmer No. 39251

P. O. Address Indep. 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.