MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

Do not use this space.

13026
207

1. PLACE OF DEATH
County Jackson — Registration District No. 399 — File No.
Township Kaw — Primary Registration District No. 1002 — Registered No.
City K.C. MO. (No. General Hospital St. Ward)

2. FULL NAME Hicks Harry
(a) Residence. No. 1114 Admoral Blvd St. Ward.
(Usual place of abode) (If nonresident, give city or town and State)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)
M	Col	Unknown

5A. IF MARRIED, WIDOWED, OR DIVORCED
HUSBAND OF
(OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Unknown

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, ...hrs. or ....min.
	38	—	—	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) K.C.
(STATE OR COUNTRY) MO.

PARENTS
10. NAME OF FATHER Hicks W. H.
11. BIRTHPLACE OF FATHER (CITY OR TOWN) Jackson
(STATE OR COUNTRY) Mo.
12. MAIDEN NAME OF MOTHER Cathey Mattie
13. BIRTHPLACE OF MOTHER (CITY OR TOWN)
(STATE OR COUNTRY) Liberty, Mo.

14. INFORMANT Hicks W. H.
(Address) 620 Charlotte

15. FILED 5/3, 1929 M. M. Crowe asst REGISTRAR

2 MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 5-1- 1929

17. I HEREBY CERTIFY, That I attended deceased from 4.28-, 1929 to 4.30-, 1929
that I last saw h. alive on 4.30-, 1929, and that
death occurred, on the date stated above, at 5:20 A m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Acute Cardiac Failure
23A
(duration) yrs. mos. ds.
CONTRIBUTORY (SECONDARY) Caseous Pneumonia
(duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH Home
DID AN OPERATION PRECEDE DEATH? — DATE OF —
WAS THERE AN AUTOPSY? —
WHAT TEST CONFIRMED DIAGNOSIS? Laboratory & Clinic
(Signed) H. M. Smith, M. D.
5/1, 1929 (Address) Old City Hosp.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) Whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL	DATE OF BURIAL
Liberty Mo	5-6 1929
20. UNDERTAKER H. B. Moore	ADDRESS 1820 E 8th

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

THIS IS A PERMANENT RECORD — WRITE WITH UNFADING INK

937