WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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.

I X14028

REC'D JUL 10 1939

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

Do not use this space. 21191

1. PLACE OF DEATH
(a) County Jackson
(b) Township Kaw
(c) City Kansas City Mo
Registration District No. 399
Primary Registration District No. 1002
Registered No. 2459
(d) Street No. Children's Mercy Hospital St.
(If death occurred in Hospital or Institution, write its name instead of street and number)
(e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME 325 Everett Sticken
(a) Residence, No. Graham Mo St.
(Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M
4. COLOR OR RACE W
5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Single
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF ✓
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) 10-4-31
7. AGE YEARS 7 MONTHS 8 DAYS 12 If LESS than 1 day, ...hrs. or ....min.

OCCUPATION
8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. None
9. Industry or business in which work was done, as saw mill, bank, etc. ✓
10. Date deceased last worked at this occupation (month and year) ✓
11. Total time (years) spent in this occupation

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Graham Mo.

FATHER
13. NAME Robert Sticken
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Bridgewater Iowa

MOTHER
15. MAIDEN NAME Sophie Finkbeiner
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Graham Mo.

17. INFORMANT (ADDRESS) Robert Sticken Graham, Mo

18. BURIAL, CREMATION, OR REMOVAL
PLACE Graham, Mo DATE June 18 1939

19. FUNERAL DIRECTOR (NAME) (ADDRESS) Campbell Funeral Home, Maryville Mo.

20. FILED June 16, 1939 M. M. Crowe, asst. Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 6-16-, 1939

22. I HEREBY CERTIFY, That I attended deceased from 6-6-, 1939, to 6-16, 1939
I last saw him alive on 6-16, 1939 Death is said to have occurred on the date stated above, at 7 a.m.
The principal cause of death and related causes of importance were as follows:

	Date of onset
Acute Rheumatic Fever	One Month
Terminal Pneumonia	
Rheumatic Fibrinous Pericarditis	

Other contributory causes of importance:

Name of operation None Date of
What test confirmed diagnosis? Clinical Was there an autopsy? Yes

23. If death was due to external causes (violence), fill in also the following:
Accident, suicide, or homicide? No Date of injury, 19
Where did injury occur? ✓
(Specify city or town, county, and State)
Specify whether injury occurred in industry, in home, or in public place.
Manner of injury ✓
Nature of injury ✓

24. Was disease or injury in any way related to occupation of deceased? No
If so, specify
(Signed) W. B. Sudenberg, M. D.
(Address) 1316 Prof. Bldg.

(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 me, ...

....., or by .....,

Registered Apprentice No....., working under my personal supervision.

Signed.....

Licensed Embalmer No.....

P. O. Address.....

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 this body is not embalmed, above space should be left blank.