

FILED JAN 8 1945

Registration District No. 72

Primary Registration District No. 5281

Registrar's No. 15

1. PLACE OF DEATH:

(a) County Clack

(b) City or town Rural Madison Mo
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:

(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 1
(Specify whether

In this community 1
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Clack

(c) City or town Rural Madison Mo
(If outside city or town limits, write "RURAL")

(d) Street No.
(If rural, give location)

(e) Citizen of foreign country? No. (Yes or No)
If yes, name country U

3. (a) PRINT FULL NAME John B. Sickels

3. (b) If veteran name war: 3. (c) Social Security No.

4. Sex Male 5. Color or race W 6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Helena Miller Sickels 6. (c) Age of husband or wife if alive 70 years

7. Birth date of deceased March 4 1864
(Month) (Day) (Year)

8. AGE: Years 80 Months 7 Days 24 If less than one day hr. min.

9. Birthplace Clack Co. Missouri
(City, town, or county) (State or foreign country)

10. Usual occupation Stock Raising + Farmer

11. Industry or business

MOTHER FATHER { 12. Name Daniel Sickels

13. Birthplace France
(City, town, or county) (State or foreign country)

14. Maiden name Louise not known

15. Birthplace Ohio
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs John B. Sickels

(b) Address Reverse Mo. R. F. D.

17. (a) Burial (b) Date thereof 10-30-44
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Kathonia Cemetery

18. (a) Signature of funeral director Fred Karle

(b) Address Kathonia, Mo

19. (a) 12-29-44 (b) Phyllis Docton
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month October day 28th
year 1944 hour 12-15 minute A. M.

21. I hereby certify that I attended the deceased from 19..... to 19.....
that I last saw h..... alive on 19.....
and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral Thrombosis 2 yrs

Due to
Due to
Other conditions
(Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy

Duration
PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify)

(b) Date of occurrence

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place?

While at work? (Specify type of place) Means of injury D

23. Signature J. M. O'Connell (M. D. or other)
Address Reverse Mo Date signed 10-30-44

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

23000

SEP 25 1947

RECEIVED

District Health Officer No. 10

District File Number 1-45-31

Date Filed JAN. 5. 1945

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..... Fred J. Karas

Licensed Embalmer No. 1023

P. O. Address. Kahoka 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 this body is not embalmed, fact should be so stated above.