

FILED OCT 13 1947

Registration District No. **37**

Primary Registration District No. **4097**

Registrar's No. **153**

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

1. PLACE OF DEATH:

(a) County Cass
 (b) City or town Harrisonville
(If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution:
2 Blocks N. 1/2 Bl. East of Square
(If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution _____
(Specify whether
 In this community 15 Years
years, months or days)

3. (a) PRINT

FULL NAME Ella Hicklin Thomas

3. (b) If veteran,

name war No

3. (c) Social Security

No. No

4. Sex Female / 5. Color or race White
 6. (a) Single, widowed, married, divorced Widowed
 6. (b) Name of husband or wife James Thomas
 6. (c) Age of husband or wife if alive — years
 7. Birth date of deceased May 25 1862
(Month) (Day) (Year)

8. AGE: Years 85 Months 4 Days 10
 If less than one day
 hr. _____ min. _____

9. Birthplace Greenwood Mo
(City, town, or county) (State or foreign country)

10. Usual occupation Home Work

11. Industry or business _____

MOTHER { 12. Name Ingram Hicklin
 13. Birthplace Greenwood Mo.
(City, town, or county) (State or foreign country)
 14. Maiden name Sallie Hayes
 15. Birthplace Tenn.
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs Goldie Hunt
 (b) Address Harrisonville Mo.
 17. (a) Burial (b) Date thereof 10-6-1947
(Burial, cremation, or removal) (Month) (Day) (Year)
 (c) Place: burial or cremation Greenwood Mo

18. (a) Signature of funeral director N.B. Langford
 (b) Address Lee's Summit Mo.
 19. (a) Oct-7-1947 (b) Laura J. Jones
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County CASS 19
 (c) City or town Harrisonville
(If outside city or town limits, write "RURAL")
 (d) Street No. 2 Bl N.E. of Square
(If rural, give location)
 (e) Citizen of foreign country? No (Yes or No)
 If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct. day 5
 year 1947 hour _____ minute 0 A.M.

21. I hereby certify that I attended the deceased from 1946 to 1947
 that I last saw her alive on JUNE 1947
 and that death occurred on the date and hour stated above.

Immediate cause of death Congestive Heart Failure
 Duration _____

Due to Essential Hypertension, Arteriosclerosis, & Senility

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

Major findings:
 Of operations _____
 Of autopsy _____

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 2
 23. Signature Paul Green (M. D. or other) D.O.
 Address Harrisonville Mo Date signed 10-6-47

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 *W.B. Langford*.....

Licensed Embalmer No..... 3833.....

P.O. Address *Lee's Summit 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.