. No. 2
—12-45
5-17-39
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WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED JAN 10 1948

Registration District No. 71

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 41162

Primary Registration District No. 3012

Registrar's No. 205

1. PLACE OF DEATH:

(a) County Clay

(b) City or town Excelsior Springs, Mo.
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: 208 Thompson St. /
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution None (Specify whether
In this community 32 years
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Clay 24

(c) City or town Excelsior Springs, Mo. /
(If outside city or town limits, write "RURAL")

(d) Street No. 208 Thompson St. /
(If rural, give location)

(e) Citizen of foreign country? No (Yes or No) 0

If yes, name country

3. (a) PRINT FULL NAME FLORA SICKEL

3. (b) If veteran, name war No

3. (c) Social Security No. None

4. Sex Fe /

5. Color or race W

6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Ben Sickel

6. (c) Age of husband or wife if alive 82 years

7. Birth date of deceased June (Month) 12, (Day) 1866 (Year)

8. AGE: Years 81 | Months 6 | Days 11 | If less than one day ___ hr. ___ min.

9. Birthplace Morrowtown (City, town, or county) Ohio / (State or foreign country)

10. Usual occupation Housewife

11. Industry or business None

FATHER
12. Name John T. Baker,
13. Birthplace (City, town, or county) Penn. / (State or foreign country)

MOTHER
14. Maiden name Martha Stubbs
15. Birthplace Cincinnati (City, town, or county) Ohio / (State or foreign country)

16. (a) Informant John Sickel
(b) Address 700 Old Orchard, Ex.Spr.Mo.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec. 24, 1947 (Month) (Day) (Year)
(c) Place: burial or cremation Masonic Cem., Ex.Spr.Mo.

18. (a) Signature of funeral director Claude Prichard
(b) Address Excelsior Springs, Mo.

19. (a) 12/24/47 (Date received local registrar) (b) Caroline Hutchings (Registrar's signature)

MEDICAL CERTIFICATION

20. **DATE OF DEATH:** Month December day 23
year 1947 hour 4 minute 00 A.M.

21. I hereby certify that I attended the deceased from 12-15, 1947, to 12-23, 1947
that I last saw her alive on 12-22, 1947
and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral Hemorrhage

Due to Vascular Sclerosis

Due to Age

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?
(Specify type of place)

While at work? (e) Means of injury 0

23. Signature J. E. Board M.D. (M.D. or other)

Address Excelsior Springs Date signed 12-23-47

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Officer No. 8,

District File Number.....
Date Filed 1-8-48

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 Lindell L. Jarman, Registered Apprentice No. 88, working under my personal supervision.

Signed Robert Ray

Licensed Embalmer No. 4182

P. O. Address Excelsior Springs, M

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.