

Registration District No. 297

Primary Registration District No. 5569

1. PLACE OF DEATH:

(a) County Jackson
(b) City or town Rural Brookings Twp
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
Inland Road 1/2 mi North of #50
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution (Specify whether)

In this community years, months or days

3: (a) PRINT FULL NAME Jarvin Gene Bickel

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

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

(b) Name of husband or wife Doris Irene Bickel 6. (c) Age of husband or wife if alive 24 years

7. Birth date of deceased Aug 20 - 1926 (Month) (Day) (Year)

8. AGE: Years 28 Months 0 Days 18 If less than one day hr. min.

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

10. Usual occupation Sheet metal Worker

11. Industry or business

12. Name Robert Bickel

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

14. Maiden name Ina Barlow

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

16. (a) Informant Doris Irene Bickel (b) Address Lees Summit Mo

17. (a) Burial (b) Date thereof 9-10-48 (Month) (Day) (Year)

(c) Place: burial or cremation Forest Hill Cem. H.G.

18. (a) Signature of funeral director H. B. Langford (b) Address Lees Summit Mo

19. (a) (Date received local registrar) (b) (Registrar's signature) A. U.

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Jackson
(c) City or town Rural Brookings Twp
(If outside city or town limits, write "RURAL")
(d) Street No. Inland Rd 1/2 mi So of #50
(If rural, give location) R.F.D. # 2 Lees Summit Mo
(e) Citizen of foreign country? No (Yes or No)
If yes, name country.

MEDICAL CERTIFICATION

20. DATE OF DEATH Month Sept day 8 year 1948 hour minute M.

21. I hereby certify that I attended the deceased from 19 to 19;

that I last saw him alive on 19 and that death occurred on the date and hour stated above.

Immediate cause of death Shock

Skull Fracture

Due to Auto Trauma

Due to (2 car accident)

Other conditions (Include pregnancy within 3 months of death) Deputy Coroner

Major findings: Of operations 1750' 22'

Of autopsy History & inspection

22. If death was due to external causes, fill in the following: (a) Accident, suicide, or homicide (specify) Accident 4/4

(b) Date of occurrence 9-8-48 (c) Where did injury occur? Jackson Mo

(d) Did injury occur: (City or town) (County) (State) No. by this Trauma

While at work? No. (Specify type of place) (e) Means of injury

23. Signature A. E. Uecher (M. D.) 2800 Main Date 9/17/48

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

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

JAN 31 1949

SEP 18 1948

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 1115 Summit St

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.