

FILED APR 4 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 7479

BIRTH NO. _____ REG. DIST. NO. 42 PRIMARY REG. DIST. NO. 1000 Registrar's No. 341

1. PLACE OF DEATH a. COUNTY Buchanan		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Missouri b. COUNTY Buchanan	
b. CITY (If outside corporate limits, write RURAL and give town) OR TOWN St. Joseph		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Joseph	
c. LENGTH OF STAY (in this place) 46 yrs		d. STREET ADDRESS (If rural, give location) 3122 Mitchell Ave.	
d. FULL NAME OF HOSPITAL OR INSTITUTION 3122 Mitchell Ave.			

3. NAME OF DECEASED (Type or Print)			4. DATE OF DEATH		
a. (First) Cash	b. (Middle) A	c. (Last) Niccum	(Month) March	(Day) 25	(Year) 1949

5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH April 23, 1878	9. AGE (In years last birthday) 70	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours	Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Engineer	10b. KIND OF BUSINESS OR INDUSTRY Railroad	11. BIRTHPLACE (State or foreign country) Wabash, Indiana	12. CITIZEN OF WHAT COUNTRY? U.S.
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13a. FATHER'S NAME William H. Niccum	13b. MOTHER'S MAIDEN NAME Sarah E.	14. NAME OF HUSBAND OR WIFE Jennie Niccum
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No	16. SOCIAL SECURITY NO. None	17. INFORMANT'S SIGNATURE OR NAME Mrs. Jennie Niccum, St. Joseph, Mo.	ADDRESS
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18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cancer - (Jaw)		
	ANTECEDENT CAUSES Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) MIX DUE TO (c) MIX		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Hemorrhage from the chest site.			

19a. DATE OF OPERATION 1948	19b. MAJOR FINDINGS OF OPERATION Major have reports on this case.	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?
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22. I hereby certify that I attended the deceased from 3-24-49, to 3-25-49, 1949, that I last saw the deceased alive on 3-24, 1949, and that death occurred at 2:22A m., from the causes and on the date stated above.

23a. SIGNATURE Robert W. Kiebar (Doctor of Medicine)	23b. ADDRESS Phys. Surg. Bldg. St. Joseph Mo.	23c. DATE SIGNED 3-25-49
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24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE 3/26/49	24c. NAME OF CEMETERY OR CREMATORY Memorial Park	24d. LOCATION (City, town, or county) (State) St. Joseph, Missouri.
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DATE REC'D BY LOCAL REG. Mar. 28, 1949	REGISTRAR'S SIGNATURE b. b. Jenkins 382	25. FUNERAL DIRECTOR'S SIGNATURE Heaton-Bowman	ADDRESS St. Joseph, Mo.
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

MAY 7 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 _____

Student Embalmer No. _____

working under my personal supervision.

Signed James B. Hawkins

Signed _____
Student Embalmer

Licensed Embalmer No. 4536

P. O. Address 319 E. 10th St. Joseph, 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.