

FILED JUL 1 1957

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

20173

STATE FILE NUMBER

Registration District No. 42 Primary Registration District No. I000 Registrar's No. 676

1. PLACE OF DEATH a. COUNTY <u>Buchanan</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Buchanan</u>			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>St. Joseph</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN <u>St. Joseph</u>		0117 0 Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTE <u>Mo. Meth. Hosp.</u>			Length of stay in lb <u>60 years</u>		d. STREET ADDRESS (If outside, give location) <u>2609 Felix St.</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) <u>GEORGE SICKEL</u>				4. DATE OF DEATH Month <u>June</u> Day <u>17</u> Year <u>1957</u>			
5. SEX <u>0</u> <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Dec. 14, 1874</u>		9. AGE (In years last birthday) <u>82</u> IF UNDER 1 YEAR Months _____ Days _____ Hours _____ Min. _____ IF UNDER 24 HRS. Months _____ Days _____ Hours _____ Min. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Ret. salesman</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Shoe Company</u>		11. BIRTHPLACE (City and state or country) <u>Baltimore, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
13. FATHER'S NAME <u>B. Sickel</u>				14. MOTHER'S MAIDEN NAME <u>Elizabeth Geher</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>			16. SOCIAL SECURITY NO. <u>unknown</u>		17. INFORMANT <u>Miss Elisabeth Sickel, 2609 Felix St. Joseph</u> Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion & myocardial rupture</u> <u>Gen Arteriosclerosis</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) DUE TO (c) <u>4201</u>							INTERVAL BETWEEN ONSET AND DEATH <u>7 hrs</u> <u>4 hrs</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (n) <u>Congestive Heart Failure: Hydrothorax</u>							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> <u>1</u>
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Hour _____ Month _____ Day _____ Year _____ a. m. _____ p. m. _____							
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION		COUNTY	STATE
21. I attended the deceased from <u>6-10-57</u> to <u>time of death</u> and last saw <u>her</u> alive on <u>6-17-57</u> Death occurred at <u>1:30 p.</u> m on the date stated above; and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE (Degree or title) <u>Mc Grinnin MD</u>				22b. ADDRESS <u>St Joseph Mo</u>		22c. DATE SIGNED <u>6-19-57</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>		23b. DATE <u>6/19/1957</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Ashland Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>St. Joseph, Missouri</u>		
24. FUNERAL DIRECTOR <u>Heaton-Borman</u> ADDRESS <u>St. Joseph, Mo.</u>			25. DATE RECD. BY LOCAL REG. <u>June 24, 1957</u>		26. REGISTRAR'S SIGNATURE <u>Mrs. Robert Fulton</u>		

Health,
Welfare
Public
Service300
1-56

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related. Coroner cannot certify to a death due to natural causes.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

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(Licensed Embalmer's Statement on Reverse Side)

JUL 17 1957

JUL 19 1957

W. Stevens

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.

Student

Signature of Student Embalmer

Signed *James B. Hawkins*

Licensed Embalmer No. 45

P. O. Address 319 S. 10th

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (If to comply with the above constitutes grounds for revocation of license).
If embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.