

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-017546

STATE FILE NUMBER

FILED MAY 18 1959 Registration District No. 141 Primary Registration District No. 3025 Registrar's No. 54

-1. PLACE OF DEATH o COUNTY <u>Lowell</u>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before death) (State and County) a. STATE <u>Mo.</u> b. COUNTY <u>Lowell</u>	
b. CITY (If outside corporate limits give TOWNSHIP only) OR TOWN <u>West Plains</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>West Plains</u> 5461
c. FULL NAME OF (If NOT in hospital, give location) : HOSPITAL OR INSTITUTION <u>West Plains Memorial 3 da.</u>		Length of stay in lb <u>3 da.</u>	d. STREET ADDRESS (If outside, give location) <u>913 Leyda</u>
3. NAME OF DECEASED (Type or print) First Middle Last <u>Velney Best Lickman</u>		4. DATE OF DEATH Month Day Year <u>4-29-59</u>	
5. SEX <u>M.</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov. 22, 1904</u>
10a. USUAL OCCUPATION (Give kind of work done during most of waking hours, or if retired)		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years Year/Day) <u>54 2 9</u> IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.
10a. <u>Book Collector</u>		10b. <u>None</u>	11. BIRTHPLACE (City and state or country) <u>Kenosha Mo.</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13a. FATHER'S NAME <u>E. B. Lickman</u>	
13b. MOTHER'S MAIDEN NAME <u>Bess Lickman</u>		13c. NAME OF HUSBAND OR WIFE <u>Mabel Lickman</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give dates of service)		16. SOCIAL SECURITY NO. <u>Yes</u>	
17. INFORMANT <u>Mabel Lickman</u>		Address <u>West Plains</u>	
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>myocardial infarction</u>			INTERVAL BETWEEN ONSET AND DEATH <u>48 hrs</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>arteriosclerotic Coronary Thrombosis</u>			<u>1 wk</u>
DUE TO (c) <u>arteriosclerosis</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Rheumatoid Arthritis</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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>4/24/59</u> to <u>4/29/59</u> and last saw him alive on <u>4/29/59</u> Death occurred at <u>9:50 P</u> m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <u>Ch. Callahan M.D.</u> (Describe or title)		22b. ADDRESS <u>West Plains, Missouri</u>	22c. DATE SIGNED <u>5/7/59</u>
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE <u>5-2-59</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Oak Lawn</u>	23d. LOCATION (City, town, or county) <u>West Plains Mo.</u>
24. FUNERAL DIRECTOR <u>Robelsons</u> ADDRESS <u>West Plains</u>		25. DATE RECD. BY LOCAL REG. <u>5-12-59</u>	26. REGISTRAR'S SIGNATURE <u>Beatrice Cook</u>

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

Physician, coroner, etc.: must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related.

3961 9 7 1953

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 *A. D. Roberts*

Licensed Embalmer No. *3432*

P. O. Address

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.