

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

=60-000334

FILED VS. FEB 15 1960 042

Registration District No. _____ Primary Registration District No. 1000 Registrar's No. 159

STATE FILE NUMBER

DED

1. PLACE OF DEATH a. COUNTY <i>Buchanan</i>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Missouri</i> b. COUNTY <i>Buchanan</i>			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <i>St. Joseph</i>		Length of stay in 1b <i>50 yrs.</i>	c. CITY OR TOWN <i>St. Joseph</i>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <i>State Hospital # 2</i>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <i>715 D. 21st St.</i>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <i>DORA</i> Middle _____ Last <i>HICKS</i>			4. DATE OF DEATH Month <i>February</i> Day <i>7</i> Year <i>1960</i>			
5. SEX <i>Female</i>	6. COLOR OR RACE <i>negro</i>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <i>Apr. 1-1884</i>	9. AGE (last birthday) <i>75</i>	IF UNDER 1 YEAR Months _____ Days _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Home</i>	11. BIRTHPLACE (City and state or country) <i>Huntsville, Mo.</i>	12. CITIZEN OF WHAT COUNTRY <i>U. S. A.</i>		
13a. FATHER'S NAME <i>Henry Rucker</i>		13b. MOTHER'S MAIDEN NAME <i>Rachel Miller</i>		14. NAME OF HUSBAND OR WIFE <i>George Hicks</i>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <i>No</i>	16. SOCIAL SECURITY NO. <i>Unknown</i>	17. INFORMANT <i>Dorothy Chamber (record)</i> Address <i>city 4093. 17th</i>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Ventricular fibrillation</i>					INTERVAL BETWEEN ONSET AND DEATH <i>4 hrs.</i>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <i>Geneslight, cerebral & coronary Arterio-sclerosis</i>					<i>8 yrs.</i>	
DUE TO (c) _____						
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <i>Hypochromic anemia & urinary tract infection - cystitis</i>				PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		
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 _____ 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 _____ to _____ and last saw her/him alive on _____ Death occurred at <i>1:55 P.</i> m on the date stated above, and to the best of my knowledge, from the causes stated.						
22a. SIGNATURE (Degree or title) <i>Mary Deeyer Ames M.D.</i>			22b. ADDRESS <i>St. Joseph, Missouri</i>		22c. DATE SIGNED <i>2-7-60</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	23b. DATE <i>Feb. 20-1960</i>	23c. NAME OF CEMETERY OR CREMATORY <i>Ashland Cemetery</i>	23d. LOCATION (City, town, or county) (State) <i>St. Joseph, Mo.</i>			
24. FUNERAL DIRECTOR <i>Wm. H. Alexander, St. Joseph, Mo.</i>		25. DATE RECD. BY LOCAL REG. <i>Feb. 9, 1960</i>	26. REGISTRAR'S SIGNATURE <i>Mrs. Charles Goodell</i>			

DOCUMENT

M. B. Ames, M.D. Medical Certification

BY AFFIDAVIT OF

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by _____
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed Wm. H. Alexander

Licensed Embalmer No. 4450

P. O. Address St. Joseph

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.