

**MISSOURI STATE BOARD OF HEALTH  
BUREAU OF VITAL STATISTICS  
CERTIFICATE OF DEATH**

Do not use this space.

6956

MAR 20 1929

1. PLACE OF DEATH  
 County Jasper Registration District No. 411 File No. 1  
 Township Wheeler Precinct Registration District No. 2002 Registered No. 92  
 City Joplin (No. Fillerman Wagon Ward)

2. FULL NAME Lucille Sick  
 (a) Residence No. \_\_\_\_\_ St. \_\_\_\_\_ Ward \_\_\_\_\_  
 (Usual place of abode)  
 Length of residence in city or town where death occurred yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds. (If nonresident give city or town and State)

**PERSONAL AND STATISTICAL PARTICULARS**

3. SEX Female 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Single  
 5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF \_\_\_\_\_  
 6. DATE OF BIRTH (MONTH, DAY AND YEAR) Aug 23, 1909  
 7. AGE YEARS MONTHS DAY IF LESS than 1 day, \_\_\_\_\_ hrs. or \_\_\_\_\_ min.  
19 6 \_\_\_\_\_  
 8. OCCUPATION OF DECEASED  
 (a) Trade, profession, or particular kind of work \_\_\_\_\_ ✓  
 (b) General nature of industry, business, or establishment in which employed (or employer) \_\_\_\_\_ ✓  
 (c) Name of employer \_\_\_\_\_

**MEDICAL CERTIFICATE OF DEATH**

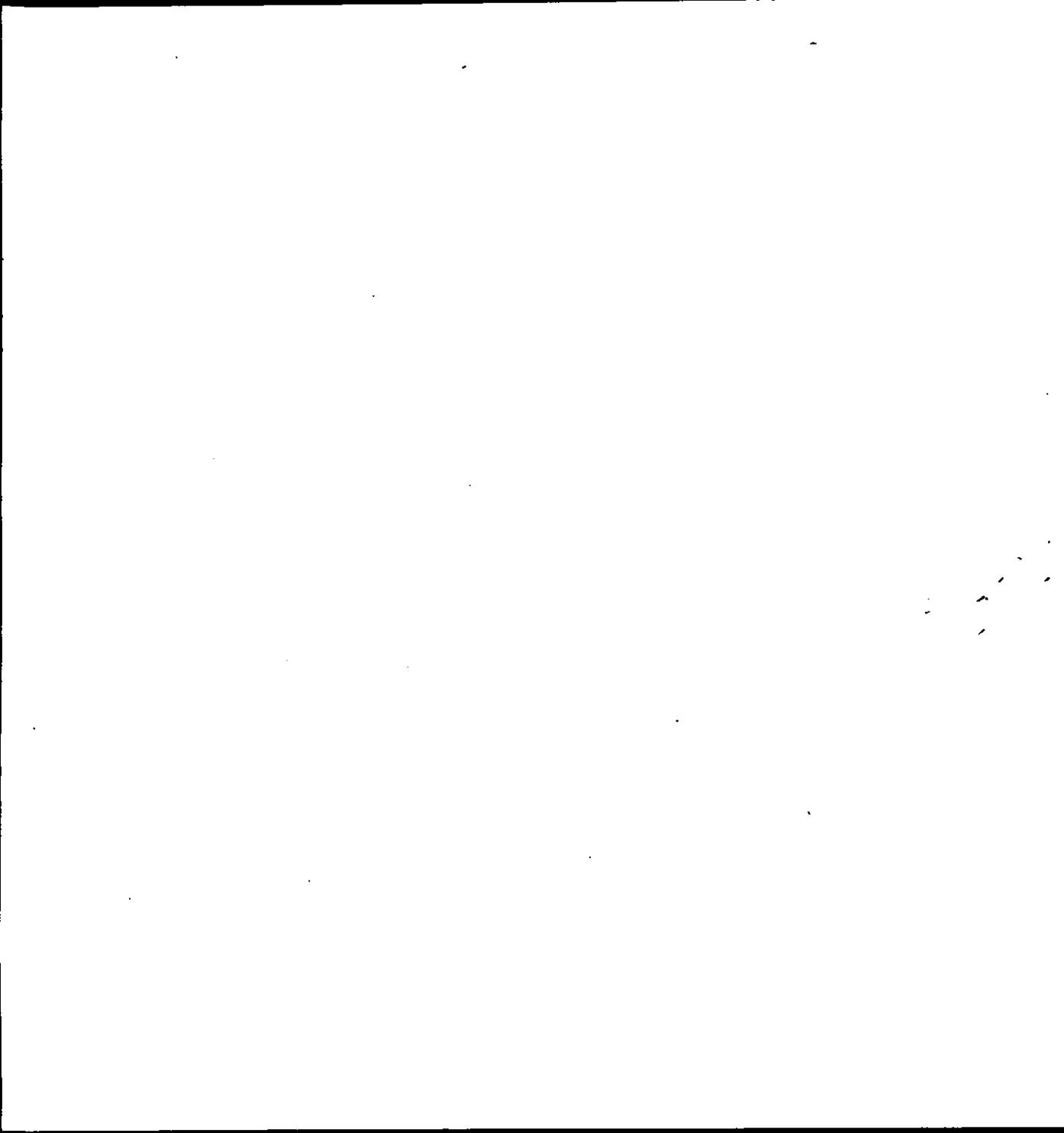
16. DATE OF DEATH (MONTH, DAY AND YEAR) 2-23-29  
 17. I HEREBY CERTIFY, That I attended deceased from 2-21-29 to 2-23-29 that I last saw him alive on 23-29-29 and that death occurred, on the date stated above, at 3-15 PM  
 THE CAUSE OF DEATH\* WAS AS FOLLOWS:  
Pelvic Abscess  
13918  
 (duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mo. \_\_\_\_\_ ds.  
 CONTRIBUTOR (SECONDARY) Surgical operations  
 (duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mo. \_\_\_\_\_ ds.

9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Joplin MO  
 10. NAME OF FATHER W.R. Sick  
 11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) Shureston Ill.  
 12. MAIDEN NAME OF MOTHER Anna Harrison  
 13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) W. Co. Tex

18. WHERE WAS DISEASE CONTRACTED  
 IF NOT AT PLACE OF DEATH? \_\_\_\_\_  
 DID AN OPERATION PRECEDE DEATH? \_\_\_\_\_ DATE OF \_\_\_\_\_  
 WAS THERE AN AUTOPSY? \_\_\_\_\_  
 WHAT TEST CONFIRMED DIAGNOSIS? \_\_\_\_\_  
 (Signed) J.C. Powers M.D.  
 (Address) Joplin Mo  
 \*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

14. INFORMANT (Address) Mrs. Anna Powers  
Joplin Mo  
 15. FILED 2-28-29 W. S. Clark REGISTRAR

19. PLACE OF BURIAL, CREMATION, OR REMOVAL W.T. Royal DATE OF BURIAL 2/26/29  
 20. UNDERTAKER (Address) W. S. Clark B ADDRESS Joplin Mo



**MISSOURI STATE BOARD OF HEALTH  
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CERTIFICATE OF DEATH**

ALL INFORMATION REQUESTED  
HEREON MUST BE WRITTEN ON  
THIS SUPPLEMENTARY.

2810

**1. PLACE OF DEATH.**

County Jasper Registration District No. 411 File No. \_\_\_\_\_  
 Township \_\_\_\_\_ Primary Registration District No. 2002 Registered No. 92  
 City Joplin (No. \_\_\_\_\_) St. \_\_\_\_\_ Ward \_\_\_\_\_

**2. FULL NAME**

Lucille Sisk

(a) Residence. No. \_\_\_\_\_ St. \_\_\_\_\_ Ward \_\_\_\_\_  
 (Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

**PERSONAL AND STATISTICAL PARTICULARS**

3. SEX F 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED S  
(write the word)

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY AND YEAR)

7. AGE YEARS MONTHS DAYS If LESS than 1 day, \_\_\_\_\_ hrs. or \_\_\_\_\_ min.

**8. OCCUPATION OF DECEASED**

(a) Trade, profession, or particular kind of work \_\_\_\_\_  
 (b) General nature of industry, business, or establishment in which employed (or employer) \_\_\_\_\_  
 (c) Name of employer \_\_\_\_\_

9. BIRTHPLACE (CITY OR TOWN) \_\_\_\_\_  
 (STATE OR COUNTRY)

PARENTS

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER (CITY OR TOWN) \_\_\_\_\_  
 (STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) \_\_\_\_\_  
 (STATE OR COUNTRY)

14.

INFORMANT \_\_\_\_\_  
 (Address)

15.

FILED 4-24-29 D. A. B. Clark  
 REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) 2-23-29

17. I HEREBY CERTIFY, That I attended deceased from \_\_\_\_\_, 19\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_, that I last saw h. \_\_\_\_\_, alive on \_\_\_\_\_, 19\_\_\_\_, and that death occurred, on the date stated above, at \_\_\_\_\_ m.

THE CAUSE OF DEATH\* WAS AS FOLLOWS:

Relapsing Abscess due to diseased tuberc.

CONTRIBUTORY (SECONDARY) \_\_\_\_\_ (duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED \_\_\_\_\_ (duration) yrs. mos. ds.

IF NOT AT PLACE OF DEATH: \_\_\_\_\_

DID AN OPERATION PRECEDE DEATH? \_\_\_\_\_ DATE OF \_\_\_\_\_

WAS THERE AN AUTOPSY? \_\_\_\_\_

WHAT TEST CONFIRMED DIAGNOSIS? \_\_\_\_\_

(Signed) Powers, M. D.  
 \_\_\_\_\_, 19\_\_\_\_ (Address)

\*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL \_\_\_\_\_ DATE OF BURIAL \_\_\_\_\_

20. UNDERTAKER \_\_\_\_\_ ADDRESS \_\_\_\_\_

**SUPPLEMENTARY**

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW

S-6956

Requested to make every effort to obtain the following information by check marks, lacking from the death certificate:

Name: Lucille Sisk

Who died at: Joplin, Mo. on Feb. 2, 1939

Residence: No. \_\_\_\_\_ St. \_\_\_\_\_  
(If nonresident, city or town)

Length of residence in city or town where death occurred: Years \_\_\_\_\_ Months \_\_\_\_\_ Days \_\_\_\_\_

Sex: \_\_\_\_\_ Color or race: \_\_\_\_\_ Single, married, widowed or divorced: \_\_\_\_\_

Date of birth: \_\_\_\_\_ Age: Years \_\_\_\_\_ Months \_\_\_\_\_ Days \_\_\_\_\_

Occupation: (a) Trade \_\_\_\_\_ (b) Industry: \_\_\_\_\_

Birthplace (State or country) \_\_\_\_\_

Birthplace of father (State or country) \_\_\_\_\_

Birthplace of mother (State or country) \_\_\_\_\_

CAUSE OF DEATH: Pelvic Abscesses

Contributory: Surgical Operations  
Trio Salpingx

Where was disease contracted? \_\_\_\_\_

Did operation precede death? \_\_\_\_\_ Date of \_\_\_\_\_

138

X

S-6956