

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

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

21868
 Do not use this space.

JUL 14 1939

1. PLACE OF DEATH

(a) County Clay Registration District No. 198
 (b) Township Fishers River Primary Registration District No. 3011
 (c) City Excelsior Springs (d) Street No. _____ St.
 (If death occurred in Hospital or Institution, write its name instead of street and number)
 (e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME

(a) Residence, No. Ray Co. Mo. - 79 yrs. St.
 (Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED Widowed
 5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Emma Sisk
 6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Sept 29, 1860
 7. AGE YEARS 79 MONTHS 1 DAYS 4 If LESS than 1 day, _____ hrs. or _____ min.
 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Farmer
 9. Industry or business in which work was done, as saw mill, bank, etc. _____
 10. Date deceased last worked at this occupation (month and year) _____ 11. Total time (years) spent in this occupation _____

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Ray Co. Mo.

FATHER 13. NAME Bartlett Sisk

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Tennessee

MOTHER 15. MAIDEN NAME Arena Grace

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Ray Co. Mo.

17. INFORMANT (ADDRESS) Elmer Sisk Ray, Co. Mo.

18. BURIAL, CREMATION, OR REMOVAL PLACE new Garden DATE June 6, 1939

19. FUNERAL DIRECTOR (NAME) (ADDRESS) Herbert Tapp Excelsior Springs, Mo.

20. FILED June 7, 1939 Miss R. M. C. C. C. Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) June 3, 1939

22. I HEREBY CERTIFY That I attended deceased from _____, 19____, to _____, 19____

I last saw h. _____ alive on _____, 19____. Death is said to have occurred on the date stated above, at 11:15 A.M.

The principal cause of death and related causes of importance were as follows:

Struck by truck on highway #10 East of Excelsior Springs Mo died in Excelsior Springs Pantheon.

Name of operation _____ Date of _____
 What test confirmed diagnosis? _____ Was there an autopsy? no

23. If death was due to external causes (violence), fill in also the following: Accident, suicide, or homicide? Accident Date of injury 6-2, 1939

Where did injury occur? _____ (Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place. highway #10
 Manner of injury fractured steel chest
 Nature of injury choked

24. Was disease or injury in any way related to occupation of deceased? no
 If so, specify _____

(Signed) W. L. W. going Coroner M. D.
 _____ (address) _____
W. M. W. acting Coroner

RECEIVED
District Health Officer No. 8,
District File Number
Date Filed 7/11/39

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,

Scott W. Hockensmith, or by

Registered Apprentice No. _____, working under my personal supervision.

Signed Scott W. Hockensmith

Licensed Embalmer No. 3597

P. O. Address Excelsior Springs, 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, above space should be left blank.