

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

33775
Do not use this space.

1. PLACE OF DEATH 3
 (a) County Vermon / Registration District No. 875
 (b) Township Washington / Primary Registration District No. 6162
 (c) City Nezuda (d) Street No. State Hospital #3 Registered No. 240
 (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 John Sizeman
 (a) Residence, No. 204 West 4th St. K.C. Mo. (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M 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) Unknown

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.
43 ? ?

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Laborer in circus

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) Unknown

13. NAME Unknown

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

15. MAIDEN NAME Unknown

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

17. INFORMANT (ADDRESS) Hosp. Record

18. BURIAL, CREMATION, OR REMOVAL PLACE Hosp. Cent. DATE 9/15

19. FUNERAL DIRECTOR (NAME) (ADDRESS) Dickinson Nevada Mo

20. FILED 9-15 1939 Allen V. Hays Local Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 9-14 1939

22. I HEREBY CERTIFY, That I attended deceased from March 1 1934, to Sept 14 1939.
 I last saw him alive on 9-14 1939. Death is said to have occurred on the date stated above, at 5 P. m.
 The principal cause of death and related causes of importance were as follows:

Date of onset

Degenerated Gumma of Rt Frontal Lobe of Brain

Other contributory causes of importance: 34

Name of operation..... Date of.....
 What test confirmed diagnosis?..... Was there an autopsy? Yes

23. If death was due to external causes (violence), fill in also the following:
 Accident, suicide, or homicide?..... Date of injury....., 19.....
 Where did injury occur?..... (Specify city or town, county, and State)
 Specify whether injury occurred in industry, in home, or in public place.

Manner of injury.....
 Nature of Injury.....

24. Was disease or injury in any way related to occupation of deceased?.....
 If so, specify.....
 (Signed) J. C. Hays, M. D.
 (Address) State Hospital
Nevada Mo.

K. 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.

RECEIVED

District Health Officer No. 7,

District File Number 7-29-1447

Date Filed 10-11-39

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, or by.....

....., Registered Apprentice No.....

working under my personal supervision.

Signed M. L. Eickinger

Licensed Embalmer No. 2686

P. O. Address Nevada

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.