

17-39  
X21492

FILED SEP 1 1940

Registration District No. **872** Primary Registration District No. **6156A** Registrar's No. \_\_\_\_\_

**1. PLACE OF DEATH:**  
(a) County Vernon  
(b) City or town Nevo  
(c) Name of hospital or institution: R. R. Station  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 2  
In this community 30 years  
(Specify whether years, months or days) 25

**3. (a) PRINT FULL NAME** SYLVAN C. SISSON  
**8. (b) If veteran,** name war 220  
**8. (c) Social Security** No. 702-18-1058

**4. Sex** M **5. Color or race** W **6. (a) Single, widowed, married, divorced** married  
**6. (b) Name of husband or wife** Herman Sisson **6. (c) Age of husband or wife if alive** 38 years  
**7. Birth date of deceased** Nov 2 26 1901  
(Month) (Day) (Year)

**8. AGE:** Years 38 Months 9 Days 17 If less than one day hr. \_\_\_\_\_ min. \_\_\_\_\_

**9. Birthplace** Batavia, Iowa  
(City, town, or county) (State or foreign country)

**10. Usual occupation** R. R. Station

**11. Industry or business** Railroad

**12. Name** Benjamin H. Sisson  
**18. Birthplace** Iowa  
(City, town, or county) (State or foreign country)  
**14. Maiden name** Sarah Carpenter  
**15. Birthplace** Iowa  
(City, town, or county) (State or foreign country)

**16. (a) Informant** Herman Sisson  
**(b) Address** 792 E Maple

**17. (a) Burial** (Burial, cremation, or removal) **(b) Date thereof** Aug 15 1940  
(Month) (Day) (Year)  
**(c) Place: burial or cremation** Scopuswood

**18. (a) Signature of funeral director** Henry H. ...  
**(b) Address** Nebraska, Mo

**19. (a)** (Date received local registrar) 7/27 **(b)** (Registrar's signature)

**2. USUAL RESIDENCE OF DECEASED:**  
(a) State Missouri (b) County Vernon  
(c) City or town Nevo  
(If outside city or town limits, write "RURAL")  
(d) Street No. 702 E Maple  
(If rural, give location)  
(e) If foreign born, how long in U. S. A. \_\_\_\_\_ years.

**MEDICAL CERTIFICATION**

**20. DATE OF DEATH:** Month Aug day 12  
year 1940 hour 7 minute 45 P. M.

**21. I hereby certify that I attended the deceased from** \_\_\_\_\_, 19\_\_\_\_; that I last saw him \_\_\_\_\_, 19\_\_\_\_; and that death occurred on the date and hour stated above.

Called by friend  
Death: Heart failure  
and died in about 15 minutes after  
Due to heart, due to acute heart failure

**Other conditions** (Include pregnancy within 3 months of death)

**Major findings:** 199  
**Of operations** \_\_\_\_\_  
**Of autopsy** None

**22. If death was due to external causes, fill in the following:**

**(a) Accident, suicide, or homicide (specify)** \_\_\_\_\_  
**(b) Date of occurrence** \_\_\_\_\_  
**(c) Where did injury occur?** \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)  
**(d) Did injury occur in or about home, on farm, in industrial place, in public place?** \_\_\_\_\_  
(Specify type of place) \_\_\_\_\_  
While at work? \_\_\_\_\_ (e) Means of injury \_\_\_\_\_

**23. Signature** P. B. Gray (M. D. or other) \_\_\_\_\_  
**Address** Nebraska **Date signed** 7/27/40

Duration

15 min

PHYSICIAN

Underline the cause to which death should be charged statistically.

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

RECEIVED

District Health Officer No. 7,

District File Number 9-40-1229

Date Filed 9-3-40

**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.....

.....  
working under my personal supervision.

Signed..... *L. B. Feary* Registered Apprentice No.....

Licensed Embalmer No. 1760

P. O. Address Nevaldal, Minn.

**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.**

No. 2B  
-2-21-40  
-1-12-259

ROWENA MOON  
WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. **29971**

Registration District No. **872**

Primary Registration District No. **6156A**

Registrar's No. \_\_\_\_\_

1. PLACE OF DEATH:

(a) County **Wessex**

(b) City or town **Waywood**  
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution \_\_\_\_\_  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether \_\_\_\_\_)

In this community \_\_\_\_\_ years, months or days

3. (a) PRINT FULL NAME **Sylvan C. Sisson**

3. (b) If veteran, name war \_\_\_\_\_

3. (c) Social Security No. \_\_\_\_\_

4. Sex **m**

5. Color or race **w**

6. (a) Single, widowed, married, divorced **m**

6. (b) Name of husband or wife \_\_\_\_\_

6. (c) Age of husband, or wife, if alive \_\_\_\_\_ years

7. Birth date of deceased (Month) (Day) (Year)

8. AGE: Years **38** Months **8** Days **17** If less than one day \_\_\_\_\_ h. \_\_\_\_\_ min.

9. Birthplace (City, town, or county) \_\_\_\_\_ (State or foreign country) \_\_\_\_\_

10. Usual occupation \_\_\_\_\_

11. Industry or business \_\_\_\_\_

MOTHER FATHER { 12. Name \_\_\_\_\_

13. Birthplace (City, town, or county) \_\_\_\_\_ (State or foreign country) \_\_\_\_\_

14. Maiden name \_\_\_\_\_

15. Birthplace (City, town, or county) \_\_\_\_\_ (State or foreign country) \_\_\_\_\_

16. (a) Informant \_\_\_\_\_

(b) Address \_\_\_\_\_

17. (a) \_\_\_\_\_ (b) Date thereof (Month) (Day) (Year)

(c) Place: burial or cremation \_\_\_\_\_

18. (a) Signature of funeral director \_\_\_\_\_

(b) Address \_\_\_\_\_

19. (a) **Aug 23, 1940** (b) **Mrs. R. H. Earl (y. e.)**  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State \_\_\_\_\_ (b) County \_\_\_\_\_

(c) City or town \_\_\_\_\_ (If outside city or town limits write "RURAL")

(d) Street No. \_\_\_\_\_ (If rural, give location)

(e) If foreign born, how long in U. S. A.? \_\_\_\_\_ years.

20. DATE OF DEATH: Month **Aug** day **12**  
year **1940** hour \_\_\_\_\_ minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_, 19\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_;  
that I last saw him alive on \_\_\_\_\_, 19\_\_\_\_,  
and that death occurred on the date and hour stated above.

Immediate cause of death \_\_\_\_\_

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions (Include pregnancy within 3 months of death) \_\_\_\_\_

Major findings: Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

Duration \_\_\_\_\_

PHYSICIAN \_\_\_\_\_

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) \_\_\_\_\_

(b) Date of occurrence \_\_\_\_\_

(c) Where did injury occur? (City or town) (County) (State) \_\_\_\_\_

(d) Did injury occur in or about home, on farm, in industrial place, in public place? \_\_\_\_\_

(Specify type of place) \_\_\_\_\_

While at work? \_\_\_\_\_ (e) Means of injury \_\_\_\_\_

23. Signature \_\_\_\_\_ (M. D. or other) \_\_\_\_\_

Address \_\_\_\_\_ Date signed \_\_\_\_\_

SUPPLEMENTAL

