

FILED MAY 15 1941

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

4398

State File No. \_\_\_\_\_

Registration District No. 259

Primary Registration District No. 4159

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

1. PLACE OF DEATH:

(a) County DEKALB  
(b) City or town MAYSVILLE Mo.  
(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 45 yrs. (Specify whether years, months or days)

3. (a) PRINT FULL NAME JOHN JACKSON SIFERS

3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

4. Sex MALE 5. Color or race WHITE 6. (a) Single, widowed, married, divorced WIDOWED  
6. (b) Name of husband or wife MELVINA SIFERS 6. (c) Age of husband or wife if alive \_\_\_\_\_ years  
7. Birth date of deceased AUG-19-1950 (Month) (Day) (Year)

8. AGE: Years - Months Days If less than one day  
90 - 8 - 2 hr. min.

9. Birthplace DEKALB Co. - MO (City, town, or county) (State or foreign country)

10. Usual occupation FARMER

11. Industry or business \_\_\_\_\_  
12. Name WILLIAM H. SIFERS  
13. Birthplace TENN. (City, town, or county) (State or foreign country)  
14. Maiden name MELVINA SLAYBAUGH  
15. Birthplace OHIO (City, town, or county) (State or foreign country)

16. (a) Informant's own signature Chas. A. Sifers  
(b) Address Mansfield Mo

17. (a) BURIAL (b) Date thereof Apr 28-41 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation MAYSVILLE CEM.

18. (a) Signature of funeral director ROBERT FONERADT HOME  
(b) Address MAYSVILLE Mo

19. (a) 4-23-41 (b) Chas. A. Sifers (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State MISSOURI (b) County DEKALB MO  
(c) City or town MAYSVILLE (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.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month APRIL day 21 year 1941 hour 6 minute 4 A. M.

21. I hereby certify that I attended the deceased from Jan 10, 1940 to Apr 21, 1941 that I last saw him alive on March 14, 1941 and that death occurred on the date and hour stated above.

Immediate cause of death Chronic Endocarditis 8 yrs. (called upon death)

Due to \_\_\_\_\_  
Due to \_\_\_\_\_  
Other conditions 92 H (Include pregnancy within 3 months of death)

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

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? \_\_\_\_\_

23. Signature Chas. A. Sifers (Specify type of place) \_\_\_\_\_  
Address Mansfield Mo (Means of injury) \_\_\_\_\_  
Date signed 4/23/41

Duration \_\_\_\_\_  
PHYSICIAN \_\_\_\_\_  
Underline the cause to which death should be charged statistically

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.

FEB 14 1958

**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.....

Licensed Embalmer No.....

P.O. Address.....

**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.**