S. No. 2
M—1-4-41
v. 5-17-39
I X28390

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. 4016

FILED FEB 9 1944

Registration District No. 1091

Primary Registration District No. 5988

Registrar's No. 5

1. PLACE OF DEATH

(a) County: Putnam

(b) City or town: Worthington (Elm Tp)
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: 1
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution ..... (Specify whether years, months or days)
In this community .....

2. USUAL RESIDENCE OF DECEASED:

(a) State: Missouri (b) County: Schuyler

(c) City or town: Queen City
(If outside city or town limits, write "RURAL")

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

(e) Citizen of foreign country? No (Yes or No)
If yes, name country .....

3. (a) PRINT FULL NAME: Joseph D. Sidwell

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 .....

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

7. Birth date of deceased: Sept. (Month) 22 (Day) 1860 (Year)

8. AGE: Years 84 Months 3 Days 16 If less than one day ..... hr. ..... min.

9. Birthplace: Missouri (City, town, or county) (State or foreign country)

10. Usual occupation: Farming

11. Industry or business .....

FATHER
12. Name: George Sidwell
13. Birthplace: Schuyler Co. (City, town, or county) Missouri (State or foreign country)

MOTHER
14. Maiden name: Esther J. Capps
15. Birthplace: Missouri (City, town, or county) (State or foreign country)

16. (a) Informant: Mrs Robert Stokesberry
(b) Address: Queencity Mo

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof: 1 19 1944 (Month) (Day) (Year)
(c) Place: burial or cremation: Tarr Cemetery

18. (a) Signature of funeral director: Wm H West
(b) Address: Queencity Mo

19. (a) 1-20-44 (Date received by local registrar) (b) [illegible] (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 1 day 18 year 1944 hour 6 minute 30 M.

21. I hereby certify that I attended the deceased from 1-17 1944 to time of death; that I last saw him alive on 1-17-44 1944; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Lobar Pneumonia	
Due to:	
Due to:	
Other conditions (Include pregnancy within 3 months of death):	
Major findings: Of operations: 108	
Of autopsy:	

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: C H Kay Exodel (M.D. or other)
Address: Greentop, Mo Date signed 1-18-44

1095

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Officer No. 10
District File Number 2-44-360
Date Filed FEB 8 1944

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 Wm H. West

Licensed Embalmer No. 2882

P. O. Address Queencity 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, fact should be so stated above.