

S. No. 2
-12-45
5-17-39
X47070

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

10679

State File No. _____

FILED APR 7 1948

318

Registration District No. _____

Primary Registration District No. _____

100

Registrar's No. _____

3026

1. PLACE OF DEATH:

(a) County St. Louis
(b) City or town St. Louis
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Evmin Desloge Hosp.
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution LIFE
(Specify whether years, months or days) LIFE

3. (a) PRINT FULL NAME Joseph Sisson

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

4. Sex Male 5. Color or race W
6. (a) Single, widowed, married, divorced 0

6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased: March 24 1948
(Month) (Day) (Year)

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

9. Birthplace St. Louis Mo
(City, town, or county) (State or foreign country)

10. Usual occupation Infant

11. Industry or business _____

MOTHER FATHER

12. Name Howard Leon Sisson

13. Birthplace Randolph Co. Ark.
(City, town, or county) (State or foreign country)

14. Maiden name Dorothy Emily Meyer

15. Birthplace St. Louis Mo
(City, town, or county) (State or foreign country)

16. (a) Informant Dorothy Sisson

(b) Address 1417 So. 10th St.

17. (a) Burial (b) Date thereof 3-29-48
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Mount Hope Cem.

18. (a) Signature of funeral director A. W. M. Langhlin

(b) Address 2801 Lafayette Ave

19. (a) MAR 29 1948 (b) J. F. Brebeck
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County 000
(c) City or town St. Louis
(If outside city or town limits, write "RURAL")
(d) Street No. 1417 So 10th Street
23 (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 27
year 1948 hour 6 minute 00 P.M.

21. I hereby certify that I attended the deceased from 3/24/48
_____ 19 _____ to 3/27/48 19 _____
that I last saw him alive on 3/27/48 19 _____
and that death occurred on the date and hour stated above.

Immediate cause of death
Hemorrhagic disease of the newborn & hemorrhage into the subarachnoid space & bilateral subpleural hemorrhage
Due to _____
Due to _____
Other conditions _____
(Include pregnancy within 3 months of death)
Major findings:
Of operations _____
Of autopsy see above

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

(c) 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? _____

While at work? _____ (Specify type of place) (c) Means of injury 0

23. Signature Vincent L. Chyle M. D. or other _____
Address 1425 McCausland Date signed 3/29/48

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

3026

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, fact should be so stated above.