

FILED JUL 26 1954

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **22198**

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. 42 PRIMARY REG. DIST. NO. 1000 Registrar's No. 797

1. PLACE OF DEATH a. COUNTY <u>Buchanan</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY <u>Buchanan</u>	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>St. Joseph</u>		c. LENGTH OF STAY (in this place) <u>70 Yrs.</u>	c. CITY OR TOWN <u>St. Joseph</u>
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>3225 South 11th St. Parkview at Sunnyslope</u>		STREET ADDRESS (If rural, give location) <u>2109 So. 10 St.</u>	

3. NAME OF DECEASED (Type or Print)	a. (First) <u>ROSELLA</u>	b. (Middle) <u>AGNES</u>	c. (Last) <u>SISKEY</u>	4. DATE OF DEATH (Month) (Day) (Year) <u>July 16, 1954</u>
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5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>	8. DATE OF BIRTH <u>Aug. 30/1877</u>	9. AGE (In years last birthday) <u>76</u>	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 1 HR. Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY _____		11. BIRTHPLACE (City and State or Foreign Country) <u>St. Joseph, Mo.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>

13a. FATHER'S NAME <u>John M. Felling</u>	13b. MOTHER'S MAIDEN NAME <u>Mary Brockus</u>	14. NAME OF HUSBAND OR WIFE <u>Frank Siskey</u>
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>	16. SOCIAL SECURITY NO. <u>none</u>	17. INFORMANT'S SIGNATURE OR NAME <u>Mrs. Louis Stedler, Elwood, Kansas</u>	ADDRESS _____
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18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)  *This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH <u>4 yrs</u>
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Chr. myocardosis and endocarditis</u>		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Hypertensive arteriosclerotic Cardio-vascular disease.</u> DUE TO (c) <u>Decompensated for four years</u>		

19a. DATE OF OPERATION _____	19b. MAJOR FINDINGS OF OPERATION _____	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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21a. ACCIDENT SUICIDE HOMICIDE (Specify) _____	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) _____	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) _____
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.) _____	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? _____
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22. I hereby certify that I attended the deceased from Jan, 1947, to 7-16, 1954, that I last saw the deceased alive on 7-12, 1954, and that death occurred at 7:10 P.M., from the causes and on the date stated above.

23a. SIGNATURE <u>Chas Grant M.D.</u> (Degree or title)	23b. ADDRESS <u>St. Joseph, Mo.</u>	23c. DATE SIGNED <u>7-17-54</u>
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24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	24b. DATE <u>July 19/54</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Mt. Olivet Cemetery</u>	24d. LOCATION (City, town, or county) (State) <u>St. Joseph, Mo.</u>
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DATE REC'D BY LOCAL REG. <u>July 20, 1954</u>	REGISTRAR'S SIGNATURE <u>Kathleen M. Allison</u>	485 -	25. FUNERAL DIRECTOR'S SIGNATURE <u>Barry Funeral Home, St. Joseph</u>	ADDRESS _____
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

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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 ....., Student Embalmer No..... working under my personal supervision..

Student.....  
Signature of Student Embalmer

Signed *Victor J. Barry*.....

Licensed Embalmer No. *421*.....

P. O. Address *St. Joseph*.....

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.  
If this body is not embalmed, fact should be so stated above.