

JRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS MAR 30 1960

60-012061

STATE FILE NUMBER

Registration District No. 275 Primary Registration District No. 3053 Registrar's No. 62

1. PLACE OF DEATH a. COUNTY <u>Phelps</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Phelps</u>									
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Rolla</u>		Length of stay in 1b <u>12da</u>		c. CITY OR TOWN <u>Newburg</u>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>							
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>McFarland Nursing</u>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside give location) <u>Newburg Rt</u>		Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>						
3. NAME OF DECEASED (Type or print) First <u>Lewis</u> Middle <u>Edward</u> Last <u>Sisco</u>				4. DATE OF DEATH Month <u>MARCH</u> Day <u>25</u> Year <u>1960</u>									
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <u>Nov 30, 1877</u>		9. AGE (last birthday) <u>82</u>		IF UNDER 1 YEAR Months <u>4</u> Days <u>25</u> Hours <u></u> Min. <u></u>		IF UNDER 24 HR Hours <u></u> Min. <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Labor</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Rail Road</u>		11. BIRTHPLACE (City and state or country) <u>Wright Co Mo</u>			12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>					
13a. FATHER'S NAME <u>John Sisco</u>				13b. MOTHER'S MAIDEN NAME <u>Nancy J Caine</u>				14. NAME OF HUSBAND OR WIFE <u>Adeline Dennis</u>					
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>702-03-9365</u>		17. INFORMANT <u>HARRISON Sisco Newburg Rt</u>							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Degenerative Heart Disease</u> DUE TO (b) <u>Arteriosclerosis</u> DUE TO (c) <u></u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.										INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)										PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)									
20c. TIME OF INJURY Hour <u></u> Month, Day, Year <u></u>		20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>											
20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION		COUNTY		STATE							
21. I attended the deceased from <u>3-16-60</u> to <u>3-25-60</u> and last saw <sup>her</sup> him <sup>live</sup> on <u>3-25-60</u> Death occurred at <u>3 p</u> m on the date stated above, and to the best of my knowledge, from the causes stated.													
22a. SIGNATURE (Degree or title) <u>Dr R. L. Stoll</u>						22b. ADDRESS <u>Rolla Mo</u>			22c. DATE SIGNED <u>3/26/60</u>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE <u>March 27, 1960</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Newburg</u>			23d. LOCATION (City, town, or county) (State) <u>Newburg Mo</u>						
24. FUNERAL DIRECTOR <u>Lee Johnson</u>				ADDRESS <u>Newburg Mo</u>		25. DATE RECD. BY LOCAL REG. <u>Mar 26, 1960</u>		26. REGISTRAR'S SIGNATURE <u>Madame L. Stoll</u>					

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

APR 15 1960

**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by \_\_\_\_\_ or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_ working under my personal supervision.

Student \_\_\_\_\_

Signature of Student Embalmer

Signed William Lee Strawder

Licensed Embalmer No. 5093

P. O. Address Newberg N

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.