

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH  
DEPARTMENT OF PUBLIC HEALTH AND WELFARE

63-033514

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 8777 STATE FILE NUMBER

**FILED SEP 6 1963**

1. PLACE OF DEATH  
a. COUNTY \_\_\_\_\_  
b. CITY (if outside corporate limits, give TOWNSHIP only) OR TOWN **St. Louis, Missouri** Length of stay in 1b \_\_\_\_\_  
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION **Cardinal Glennon Memorial Hospital** Inside Limits \_\_\_\_\_  
d. STREET ADDRESS (if outside, give location) **112 S. Drive** Reside on Farm Yes  No

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)  
a. STATE **Missouri** b. COUNTY **St. Louis**  
c. CITY OR TOWN **Sherman, Missouri** Inside Limits Yes  No   
d. STREET ADDRESS (if outside, give location) **112 S. Drive** Reside on Farm Yes  No

3. NAME OF DECEASED (Type or print) First **Linda** Middle **Jo** Last **Cisco** 4. DATE OF DEATH Month **8** Day **30** Year **1963**

5. SEX **Female** 6. COLOR OR RACE **White** 7. Married  Never Married  Widowed  Divorced  8. DATE OF BIRTH **6/27/60** 9. AGE (last birthday) **3 yrs** IF UNDER 1 YEAR Months \_\_\_\_\_ Days \_\_\_\_\_ IF UNDER 24 HR Hours \_\_\_\_\_ Min. \_\_\_\_\_

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) **None** 10b. KIND OF BUSINESS OR INDUSTRY **None** 11. BIRTHPLACE (City and state or country) **Mountain View, Mo.** 12. CITIZEN OF WHAT COUNTRY **U.S.A.**

13a. FATHER'S NAME **Albert Cisco** 13b. MOTHER'S MAIDEN NAME **Opal (Hart) Payne** 14. NAME OF HUSBAND OR WIFE **Nil.**

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) **No. Nil.** 17. INFORMANT **Mrs. Opal Payne, Sherman, Mo.** Address \_\_\_\_\_

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:  
IMMEDIATE CAUSE (a) **Convulsions.** INTERVAL BETWEEN ONSET AND DEATH **2 hours**  
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) **Acute Respiratory Infection** **3 day**  
DUE TO (c) **Renal Rickets** **Life**  
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) **594x** PART III. If deceased was female was there a pregnancy in last 90 days.  Yes  No  Unknown

19. WAS AUTOPSY PERFORMED? YES  NO  20a. ACCIDENT  SUICIDE  HOMICIDE  20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.) \_\_\_\_\_

20c. TIME OF INJURY Hour \_\_\_\_\_ a.m. \_\_\_\_\_ p.m. Month, Day, Year \_\_\_\_\_

20d. INJURY OCCURRED WHILE AT WORK  NOT WHILE AT WORK  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 **January 1962** to **8/30/63** and last saw her **alive** on **8/30/63**  
Death occurred at **10 45** a.m. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE **X. Dieh M.D.** (Degree or title) 22b. ADDRESS **634 N. Grand** 22c. DATE SIGNED **8/22/63** (State)

23a. BURIAL, CREMATION, REMOVAL (Specify) **Removal** 23b. DATE **8-31-63** 23c. NAME OF CEMETERY OR CREMATORY **Local** 23d. LOCATION (City, town, or county) **Reno, Arkansas.**

24. FUNERAL DIRECTOR **Albert H. Hoppe Inc., 4700 Washington, Blvd** ADDRESS \_\_\_\_\_ 25. DATE RECD. BY LOCAL REG. **AUG 30 1963** 26. REGISTRAR'S SIGNATURE **Joan Smith, M.D.**

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DATE AMENDED  
AMENDMENTS ON THIS RECORD ARE AS FOLLOWS  
INSTEAD OF  
SHOULD READ

DOCUMENT  
MEDICAL CERTIFICATION  
BY AFFIDAVIT OF

USE BLACK INK OR TYPEWRITER RIBBON

**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 *John J. Haerin*  
Licensed Embalmer No. 4108

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