

**MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH**

Do not use this space.

4539

1. PLACE OF DEATH

48 County Jackson Registration District No. 398
5 Township Blue Primary Registration District No. 3019
8 City Independence

File No. _____
Registered No. 44
St. _____ Ward) _____

2. FULL NAME

Cynthia L. Sischo
(a) Residence. No. 722 S. Park St., _____ Ward. _____
(Usual place of abode) (If nonresident, give city or town and State)
Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX female 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED OR DIVORCED widow
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Sam. Cline
Sylvester Sischo
6. DATE OF BIRTH (MONTH, DAY AND YEAR) Nov. 8, 1841
7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min.
90 2 27

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work House Keeper
(b) General nature of industry, business, or establishment in which employed (or employer) _____
(c) Name of employer _____

9. BIRTHPLACE (CITY OR TOWN) _____
(STATE OR COUNTRY) Canada

10. NAME OF FATHER Nelson Tower
11. BIRTHPLACE OF FATHER (CITY OR TOWN) _____
(STATE OR COUNTRY) Canada
12. MAIDEN NAME OF MOTHER Cynthia Carter
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) _____
(STATE OR COUNTRY) Canada

14. INFORMANT Cynthia Cline
(Address) 722 S. Park

15. FILED M. E. Cook REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Feb 4 1932
17. I HEREBY CERTIFY, That I attended deceased from Feb 1, 1932, to Feb 4, 1932
that I last saw him alive on Feb 4, 1932, and that death occurred, on the date stated above, at 6 a. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Acute Myocarditis
10 17 0
10 17 0
10 17 0 (duration) yrs. mos. ds.
CONTRIBUTORY Heartburn & Constipation
(SECONDARY) menstr. faculy. loss & hip
fractured left hip July 23, 1928.

16. WHERE WAS DISEASE CONTRACTED _____
IF NOT AT PLACE OF DEATH _____
DID AN OPERATION PRECEDE DEATH? no DATE OF (1)
WAS THERE AN AUTOPSY? no
WHAT TEST CONFIRMED DIAGNOSIS Clinical
(Signed) C. H. Allen, M. D.
2-4-1932 (Address) Independence

19. PLACE OF BURIAL, CREMATION, OR REMOVAL Mound Grove Cem. DATE OF BURIAL 2-5-1932

20. UNDERTAKER J. L. Latta ADDRESS 214 N. Spring St. Independence, Mo.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. WITH UNFADING INK—THIS IS A PERMANENT RECORD. MAR. 9 1932

Please state
cause of
fractured hip

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CERTIFICATE OF DEATH**

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

1. PLACE OF DEATH

County Jackson
Township Independence
City Independence (No.)

Registration District No. 398
Primary Registration District No. 3019

File No.
Registered No. 44
St. Ward)

2. FULL NAME

(a) Residence, No. St. Ward.
(Usual place of abode) (If nonresident, give city or town and State)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX <u>F</u>	4. COLOR OR RACE <u>W</u>	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) <u>Wid</u>
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF		
6. DATE OF BIRTH (MONTH, DAY, AND YEAR)		
7. AGE	YEARS	MONTHS
		DAYS
		If LESS than 1 day, hrs. or min.
8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc.		11. Total time (years) spent in this occupation
9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.		
10. Date deceased last worked at this occupation (month and year)		

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

13. NAME

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

15. MAIDEN NAME

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

17. INFORMANT (ADDRESS)

18. BURIAL, CREMATION, OR REMOVAL PLACE DATE

19. UNDERTAKER (ADDRESS)

20. FILED April 15 1933 F. L. Book Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Feb 4 1932

22. I HEREBY CERTIFY, That I attended deceased from 19....., to 19.....
I last saw h..... alive on 19..... Death is said to have occurred on the date stated above, at m.
The principal cause of death and related causes of importance were as follows:

Senile myocarditis Date of onset
1860

Other contributory causes of importance: 14
Fracture of femur & Compartment syndrome
fracture of hip
fell in the home
two years before
Name of operation Date of
What test confirmed diagnosis? Was there an autopsy?

23. If death was due to external causes (violence), fill in also the following:
Accident, suicide, or homicide? Date of injury 19.....
Where did injury occur? (Specify city or town, county, and State)
Specify whether injury occurred in industry, in home, or in public place.

Manner of injury
Nature of injury

24. Was disease or injury in any way related to occupation of deceased?
If so, specify
(Signed) M. D.
(Address)

SUPPLEMENTARY

N. B.—Every item of information should be carefuly supplied. AGE should be stated EXACTLY. PHYSICIAN'S should state CAUSE properly classified. Exact statement of OCCUPATION is very important. REGISTER ALL NOT RECEIVE A CERTIFICATE UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW