

MISSOURI STATE BOARD OF HEALTH

BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

35780  
Do not use this space.

1. PLACE OF DEATH  
 (a) County Cape Girardeau Registration District No. 171  
 (b) Township Keokuk Primary Registration District No. 4100  
 (c) City Keokuk (d) Street No. \_\_\_\_\_ St.  
 (If death occurred in Hospital or Institution, write its name instead of street and number)  
 (e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME RACHEL ANN SISLER

(a) Residence, No. \_\_\_\_\_ St.  (If nonresident, give city or town and State)  
 (Usual place of abode, if no street address, write county or city)

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 George Sisler (OR) WIFE OF \_\_\_\_\_  
 6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Sept 6<sup>th</sup> 1859  
 7. AGE YEARS 80 MONTHS 1 DAYS 6 If LESS than 1 day, \_\_\_\_\_ hrs. \_\_\_\_\_ min.  
 OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Housekeeper  
 9. Industry or business in which work was done, as saw mill, bank, etc. \_\_\_\_\_  
 10. Date deceased last worked at this occupation (month and year) Aug 1939 11. Total time (years) spent in this occupation Call S. S.  
 12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Keokuk Mo.  
 FATHER 13. NAME John K. Regburn  
 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Virginia ?  
 MOTHER 15. MAIDEN NAME Elizabeth Ann Danvers  
 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Mo. Kentucky  
 17. INFORMANT Mrs. W. B. Oldham (ADDRESS) Keokuk  
 18. BURIAL, CREMATION, OR REMOVAL PLACE Keokuk DATE Oct 14 1939  
 19. FUNERAL DIRECTOR (NAME) (ADDRESS) W. H. & Son Keokuk  
 20. FILED 10/15/39 Dr. Roy Sandree Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Oct 12<sup>th</sup> 1939  
 22. I HEREBY CERTIFY, That I attended deceased from Aug 23 1939, to Oct 13 1939  
 I last saw her alive on Oct 13 1939. Death is said to have occurred on the date stated above, at 4:30 P.M.  
 The principal cause of death and related causes of importance were as follows:  
Hypostatic passive pulmonary congestion Date of onset Oct 7-39  
 Other contributory causes of importance:  
Fracture necessitated by fractured femur  
 Name of operation none Date of \_\_\_\_\_  
 What test confirmed diagnosis? auscultation Was there an autopsy? no  
 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? no  
 If so, specify \_\_\_\_\_  
 (Signed) W. H. & Son M. D.  
 (Address) Keokuk Mo.

WRITE PLAINLY, WITH UNFADING INK---THIS IS A PERMANENT RECORD

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.

V. S. NO. 2. 50M-1-12-38 I X14023

1942  
9/17

DEPARTMENT OF HEALTH  
STATE OF TEXAS

RECEIVED

RECEIVED  
District Health Officer No. 8,  
District File Number  
11/6/39  
Date Filed

**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, .....

*H. D. Barnett*

..... or by .....

Registered Apprentice No....., working under my personal supervision.

Signed.....  
*H. D. Barnett*

Licensed Embalmer No. *3046*

P. O. Address *Keyville*

**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, above space should be left blank.**

FILL IN ANSWERS TO ALL SPACES  
CHECKED IN RED PENCIL.

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

35780  
Do not use this space.

1. PLACE OF DEATH  
 (a) County Chariton Registration District No. 171  
 (b) Township Keytesville Primary Registration District No. 4100 Registered No. 20  
 (c) City Keytesville (d) Street No. \_\_\_\_\_ St.  
 (If death occurred in Hospital or Institution, write its name instead of street and number)  
 (e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U.S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME Rachel Ann Sisler  
 (a) Residence, No. \_\_\_\_\_ St.  (If nonresident, give city or town and State)  
 (Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX 7 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED Wid  
 (write the word)

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.  
80 1 6

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. \_\_\_\_\_  
 OCCUPATION 9. Industry or business in which work was done, as saw mill, bank, etc. \_\_\_\_\_  
 10. Date deceased last worked at this occupation (month and year) \_\_\_\_\_ 11. Total time (years) spent in this occupation \_\_\_\_\_

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

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Oct 12, 1939

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:  
Hypostatic passive pulmonary congestion  
posture necessitated by fractured femur  
 Date of onset Oct 11/39

Other contributory causes of importance: \_\_\_\_\_  
posture necessitated by fractured femur

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? accident Date of injury 8-20, 1939  
 Where did injury occur? home - Keytesville Mo  
 (Specify city or town, county, and State)  
 Specify whether injury occurred in industry, in home, or in public place.  
in home - due to a fall  
 Manner of injury \_\_\_\_\_  
 Nature of injury Complete fracture of neck of femur

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

SUPPLEMENTARY

13. NAME \_\_\_\_\_  
 BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) \_\_\_\_\_

14. NAME \_\_\_\_\_  
 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\_\_\_\_

19. FUNERAL DIRECTOR (ADDRESS) \_\_\_\_\_

20. FILED \_\_\_\_\_ 19\_\_\_\_  
 Local Registrar \_\_\_\_\_

WRITE PLAINLY, WITH UNFADING INK---THIS IS A PERMANENT RECORD

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.

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAW.

