

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

3245
Do not use this space.

1. PLACE OF DEATH
 (a) County Oregon Registration District No. 636 45-50
 (b) Township Woodside Primary Registration District No. 5843
 (c) City Alton (d) Street No. _____ Registered No. 2
 (If death occurred in Hospital or Institution, write its name instead of street and number) St. _____
 (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 163 Aggie Lou Sifford

(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 (write the word) Single
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF _____
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Aug. 1, 1935
7. AGE
 YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min.
 4 4 4
8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc.
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) Boise, Idaho

FATHER
13. NAME Robert Lee Sifford
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Missouri

MOTHER
15. MAIDEN NAME Clessie Bell
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Missouri

17. INFORMANT (ADDRESS) Robert Lee Sifford Alton, Mo.

18. BURIAL, CREMATION, OR REMOVAL PLACE Hickory Grove DATE 12/6/39

19. FUNERAL DIRECTOR (NAME) (ADDRESS) Leo Carr Thayer, Mo.

20. FILED 1/4 1940 Enoch Bailey Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Dec. 5, 1939
22. I HEREBY CERTIFY, That I attended deceased from Dec 5th 1939 to Dec 5th 1939
 I last saw him alive on Dec 5th 1939. Death is said to have occurred on the date stated above, at 4:00 a.m. M.
 The principal cause of death and related causes of importance were as follows:

Angerthia
 Date of onset 12-3-39
 ID

Other contributory causes of importance:
 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) E. W. Cooper, M. D.
 (Address) Thayer 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.

FILED FEB 3 1940

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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 _____

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

Signed _____

Licensed Embalmer No. _____

P. O. Address _____

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.