

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **21986**

Registration District No. **411**

Primary Registration District No. **2002**

Registrar's No. _____

1. PLACE OF DEATH:

(a) County **Jasper**
(b) City or town **Joplin**
(c) Name of hospital or institution: **St. Johns Hospital**
(d) Length of stay: In hospital or institution **3 hours**
In this community **3 YRS.**

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **Jasper**
(c) City or town **Joplin**
(d) Street No. **1038 Pennsylvania**
(e) If foreign born, how long in U. S. A. _____ years.

3. (a) PRINT FULL NAME **Mrs Mattie Mae Sisson Callentine**

3. (b) If veteran, name war ******* 3. (c) Social Security No. *******

4. Sex **Female** 5. Color or race **White** 6. (a) Single, widowed, married, divorced **Married**
6. (b) Name of husband or wife **Arthur Callentine** 6. (c) Age of husband or wife if alive **32** years
7. Birth date of deceased **June 10, 1918**

8. AGE: Years **23** Months **0** Days **15** If less than one day hr. _____ min. _____

9. Birthplace **Monett Missouri**

10. Usual occupation **Housewife**

11. Industry or business **Home**

MOTHER FATHER { 12. Name **Baker S. Sisson**
13. Birthplace **Alabama**
14. Maiden name **Gertie Stewart**
15. Birthplace **Kansas**

16. (a) Informant **Mrs. Gertie Sisson**

(b) Address **1038 Penn., Joplin, Mo.**

17. (a) **Burial** (b) Date thereof **6-27-40**

(c) Place: burial or cremation **I.O.O.F. Cem., Monett, Mo.**

18. (a) Signature of funeral director **Hurlbut Ind. Co.**

(b) Address **212 Joplin St., Joplin, Mo.**

19. (a) **6-26-40** (b) **Ed D. Jerney**

(Licensed Embalmer's Statement on Reverse Side)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **6th** day **25th** 19**40**
year _____ hour **2** minute **45 P.M.**

21. I hereby certify that I attended the deceased from _____ to _____ 19____
that I last saw her alive on **June 25, 1940**

and that death occurred on the date and hour stated above.
Immediate cause of death **Shot through right temple, 25 cal Remington-Union pistol**
Due to **Homicide**

Due to _____

Other conditions (Include pregnancy within 3 months of death) _____

Major findings: Of operations _____
Of autopsy **Investigation**

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify) **Homicide**
(b) Date of occurrence **June 25, 1940**
(c) Where did injury occur? **Joplin, Jasper, Mo**
(d) Did injury occur in or about home, on farm, in industrial place, in public place?
Home - shot with
While at work? **No** (Specify type of place) _____
(e) Means of injury **Shot**
23. Signature **H. C. Winchester** (D. or other) _____
Address **Joplin, Mo** Date signed **6-25-40**

PHYSICIAN
Underline the cause to which death should be charged statistically.

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

9
7
5

173

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 Sam E. Sorenson

Licensed Embalmer No. 4079

P.O. Address Joplin 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 this body is not embalmed, above space should be left blank.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **21986**

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

Registration District No. **411**

Primary Registration District No. **2002**

Registrar's No. _____

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH:

(a) County **Jackson**
(b) City or town **Jackson**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution _____
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether)
In this community _____ (Specify whether)
years, months or days

3. (a) PRINT FULL NAME

Mattie Mae Sisson Calentine

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex **F** 5. Color or race **W** 6. (a) Single, widowed, married, divorced **W**

6. (b) Name of husband or wife _____ 6. (c) Age of husband, or wife, if alive _____ years

7. Birth date of deceased _____ (Month) (Day) (Year)

8. AGE: Years **23** Months **0** Days **15** If less than one day _____ min.

9. Birthplace _____ (City, town, or county) (State or foreign country)

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER { 12. Name _____
13. Birthplace _____ (City, town, or county) (State or foreign country)
14. Maiden name _____
15. Birthplace _____ (City, town, or county) (State or foreign country)

16. (a) Informant _____ (b) Address _____

17. (a) _____ (b) Date thereof _____ (Month) (Day) (Year)
(Burial, cremation, or removal)
(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____ (b) Address _____

19. (a) _____ (b) _____ (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State _____ (b) County _____
(c) City or town _____ (If outside city or town limits write "RURAL")
(d) Street No. _____ (If rural, give location)
(e) If foreign born, how long in U. S. A.? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH _____ month **6** day **20** -
year **1940** hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____;
that I saw him _____ alive on _____, 19____;
and that death occurred on the date and hour stated above.

Immediate cause of death **Gunshot right temple 20-cal automatic Colt pistol**

Due to **Homicide**
Due to **Homicide**

Other conditions _____ (Include pregnancy within 3 months of death)

Major findings: Of operations **172**
Of autopsy _____

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) _____
(b) Date of occurrence _____
(c) Where did injury occur? _____ (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

While at work? _____ (Specify type of place) (e) Means of injury _____

23. Signature **G. H. Winchester** M.D. or other _____
Address **Jackson** _____ Date signed _____

SUPPLEMENTAL COPY

