

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **37577**
4175
Registrar's No.

Registration District No. **399**

Primary Registration District No. **1002**

1. PLACE OF DEATH:

(a) County **Jackson**
(b) City or town **Kansas City**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
K.C. General Hospital No. 1
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **15 days**
(Specify whether
In this community **85 years**
years, months or days)

3. (a) PRINT FULL NAME **FRANK SISCO**

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

4. Sex **Male** 5. Color or race **White** 6. (a) Single, widowed, married, divorced **Single**
6. (b) Name of husband or wife. 6. (c) Age of husband or wife if alive **1848** years

7. Birth date of deceased **Aug. 6th** **1848**
(Month) (Day) (Year)

8. AGE: Years **92**, Months **2**, Days **2** If less than one day hr. min.

9. Birthplace **Lyons New York**
(City, town, or county) (State or foreign country)

10. Usual occupation **None**

11. Industry or business **23**

12. Name **Sullivan Sisco**
13. Birthplace **New York**
(City, town, or county) (State or foreign country)

14. Maiden name **Mary Scott**
15. Birthplace **Canada**
(City, town, or county) (State or foreign country)

16. (a) Informant **Record Clerk**
(b) Address **K.C. Gen. Hosp.**

17. (a) **Burial** (b) Date thereof **10-31-40**
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation **Municipal Cemetery**

18. (a) Signature of funeral director **W.A. Lohmeyer**
City mortician
(b) Address **11-1-40**

19. (a) **11-1-40** (b) **M. M. Brown**
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **Jackson**
Kansas City
(c) City or town **Kansas City**
(If outside city or town limits, write "RURAL")
(d) Street No. **514 1/2 Main St.**
(If rural, give location)
(e) If foreign born, how long in U. S. A. ? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Oct.** day **8th**
year **1940** hour **3** minute **35** A. M.

21. I hereby certify that I attended the deceased from **9-23-40**, 19____, to **10-8-40**, 19____;
that I last saw him alive on **10-8-40**, 19____;
and that death occurred on the date and hour stated above.

Immediate cause of death:
CHRONIC DIFFUSE GLOMERULAR NEPHRITIS WITH UREMIA

Due to _____
Due to **131**

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

Major findings:
Of operations _____
Of autopsy **None**

Duration _____
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? _____

(Specify type of place) _____
While at work? _____ (e) Means of injury **1**
23. Signature **Dorothy R. Thom** (M. D. or other) _____
Address **Med. Dir., K.C. Gen. Hospital** Date signed **10-29-40**

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

FILED DEC 1 1940

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.