

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS  
STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

34087

State File No. \_\_\_\_\_

Registration District No. 184

Primary Registration District No. 3038

Registrar's No. 104

1. PLACE OF DEATH:

(a) County LINN

(b) City or town BROOKFIELD  
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:  
126 W DAKE /  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution none  
(Specify whether in this community years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Linn 58

(c) City or town Brookfield 1  
(If outside city or town limits, write "RURAL")

(d) Street No. 126 W Dake 2  
(If rural, give location)

(e) Citizen of foreign country? No (Yes or No) 0  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME CLAY VIVIAN SIDENER

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

4. Sex M 5. Color or race W 6. (a) Single, widowed, married, divorced 1

6. (b) Name of husband or wife MINNIE 6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased JANUARY 17 1873  
(Month) (Day) (Year)

8. AGE: Years 73 Months 8 Days 19 If less than one day hr. \_\_\_\_\_ min. \_\_\_\_\_

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

10. Usual occupation Dentist

11. Industry of Business \_\_\_\_\_

12. Name Noah Sidener

13. Birthplace Unknown  
(City, town, or county) (State or foreign country)

14. Maiden name Unknown

15. Birthplace \_\_\_\_\_  
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs Sidener

(b) Address 126 W DAKE, BROOKFIELD, MO

17. (a) Burial (b) Date thereof Oct 8 - 1946  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Rose Hill

18. (a) Signature of funeral director Ray Erwin

(b) Address 418 Linn, Brookfield, MO

19. (a) 10/7/46 (b) WB Erwin  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct day 6th  
year 1946 hour 7 minute 00 A.M.

21. I hereby certify that I attended the deceased from Sept 29 1946 to Oct 5 1946  
that I last saw him alive on Oct 5 1946  
and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral Hemorrhage - E.D.C. apoplexy

Due to General Arterio-Sclerosis

Due to \_\_\_\_\_

Other conditions (Include pregnancy within 3 months of death) \_\_\_\_\_

Major findings: \_\_\_\_\_

Of operations \_\_\_\_\_

Of autopsy 83A

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 Ray R. Halsey (M. D. or other) MD  
Address Brookfield Date signed 10.7.46

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

8  
1  
2

DISTRICT HEALTH OFFICE  
Cameron, Mo.

JUN 1 1945

---

---

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, fact should be so stated above.**