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Rev. 5-17-39
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No.

FILED APR 8 1947
Registration District No. 3974

Primary Registration District No. 4547

Registrar's No. 24

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

1. PLACE OF DEATH
(a) County Worth
(b) City or town Grant City
(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 life years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Mo (b) County Worth
(c) City or town Grant City
(If outside city or town limits, write "RURAL")
(d) Street No. _____ (If rural, give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME Lettsonia Victoria Sisk
3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month 3 day 21
year 1947 hour 20 minute 0 M.
21. I hereby certify that I attended the deceased from 3-10-
1947 to 3-21, 1947;
that I last saw her alive on 3-21, 1947;
and that death occurred on the date and hour stated above.

4. Sex female 5. Color or race white 6. (a) Single, widowed, married, divorced widow 2
6. (b) Name of husband or wife James Albert Sisk 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased October 1 1859
(Month) (Day) (Year)

Immediate cause of death Influenza
Duration 68 days

8. AGE: Years 87 Months 5 Days 20 If less than one day _____ hr. _____ min.

Due to _____
Due to _____
Other conditions Myocardial Regeneration of heart
(Include presence within 3 months of death)

9. Birthplace Indiana
(City, town, or county) (State or foreign country)
10. Usual occupation housewife

PHYSICIAN
Major findings: no
Of operations _____
Of autopsy no
Underline the cause to which death should be charged statistically.

11. Industry or business _____
12. Name Joseph Sanders
13. Birthplace Indiana
(City, town, or county) (State or foreign country)
14. Maiden name Sarah Ann Davidson
15. Birthplace Indiana
(City, town, or county) (State or foreign country)

16. (a) Informant Jade Snyder
(b) Address Grant City, Mo

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? _____

17. (a) burial (b) Date thereof 3-23-47
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation: Grant City Cemetery
18. (a) Signature of funeral director Arch C. Duffell
(b) Address Grant City, Mo
19. (a) March 27-47 (b) Reta E. Dawson
(Data received local registrar) (Registrar's signature)

While at work? _____ (Specify type of place) (c) Means of injury 0
23. Signature J. Case MD (M., D., or other)
Address Grant City, Mo Date signed 3-22-47

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SEP 19 1947

DISTRICT HEALTH OFFICE
Cameron, Mo.

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 *Arch C. Dwyer*

Licensed Embalmer No. *3252*

P. O. Address *Grant city 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, fact should be so stated above.