

FILED SEP 11 1947

Registration District No. 144

Primary Registration District No. 55362

Registrar's No. 21

1. PLACE OF DEATH:

(a) County Iron  
(b) City or town Acadia-Rural  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: The Home for Aged Baptists 5  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 1 mo. 7 18 days  
(Specify whether  
In this community 1 month 7 18 days  
years, months or days)

3. (a) PRINT FULL NAME John Porter Sidener

3. (b) If veteran, name war none 3. (c) Social Security No. none

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Widowed

6. (b) Name of husband or wife Emma Oliver 6. (c) Age of husband or wife if alive Deceased years

7. Birth date of deceased August 2, 1861  
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day  
85 1 1 hr. min.

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

10. Usual occupation Farmer

11. Industry or business Farming

12. Name Wm P. Sidener

13. Birthplace Burton Co. Ky.  
(City, town, or county) (State or foreign country)

14. Maiden name Mauda J. Warren

15. Birthplace Monroe Co. Mo.  
(City, town, or county) (State or foreign country)

16. (a) Informant John H. Barney

(b) Address Fronton, Mo.

17. (a) Removed (b) Date thereof 9-4-47  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation New Florence

18. (a) Signature of funeral director Norman White D.S.

(b) Address Fronton, Mo.

19. (a) 9-8-47 (b) Arce Jones  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Iron 47  
(c) City or town Acadia-Rural 0  
(If outside city or town limits, write "RURAL") 0  
(d) Street No. 1/2 Mile East on Highway 70 0  
(If rural, give location)  
(e) Citizen of foreign country? No. (Yes or No)  
If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept. day 3.  
year 1947 hour 7:40 minute P. M.

21. I hereby certify that I attended the deceased from 8-29 1947 to 9-3-47 1947  
that I last saw him alive on 8-29 1947  
and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral hemorrhage 8-29-47

Due to heat prostration 8-29-47

Due to \_\_\_\_\_  
Other conditions Senility ?  
(include pregnancy within 3 months of death)

Major findings:  
Of operations \_\_\_\_\_  
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) (a) Means of injury \_\_\_\_\_

23. Signature J.P.E. Farland (M. D. or other) M.D.  
Address Fronton Date signed 9-4-47

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

RECEIVED

Health Officer No. 4

Number 947-117

DATE 9-10-47

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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 *Russell White*

Licensed Embalmer No. *2012*

P. O. Address *Imitor Ave*

**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.**