

FILED DEC 12 1950

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

38018

State File No.

BIRTH NO. _____ REG. DIST. NO. 277 PRIMARY REG. DIST. NO. 4412 Registrar's No. 51

1. PLACE OF DEATH a. COUNTY <u>Pike</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Pike</u>	
b. CITY OR TOWN <u>Curryville</u>		c. CITY OR TOWN <u>Curryville</u>	
c. LENGTH OF STAY (in this place)		d. STREET ADDRESS (If rural, give location)	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>at Home</u>			
3. NAME OF DECEASED a. (First) <u>Harvey</u> b. (Middle) <u>William</u> c. (Last) <u>Sisson</u>			4. DATE OF DEATH (Month) (Day) (Year) <u>11 - 3 - 1950</u>
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>	8. DATE OF BIRTH <u>Sept 30 - 1867</u>
9. AGE (In years last birthday) <u>83</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farming</u>	11. BIRTHPLACE (State or foreign country) <u>Pike Co Missouri</u>
10a. USUAL OCCUPATION		10b. KIND OF BUSINESS OR INDUSTRY <u>Retired</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13a. FATHER'S NAME <u>Frank L. Sisson</u>		13b. MOTHER'S MAIDEN NAME <u>Mary Rebecca Wright</u>	14. NAME OF HUSBAND OR WIFE <u>Clara James Sisson</u>
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <input checked="" type="checkbox"/> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <input checked="" type="checkbox"/>	17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>Clara Sisson - Curryville Mo</u>
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). *This does not mean the mode of dying, such as heart failure, ashenia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Myocardial Infarction</u> ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Cardio Vascular renal Morbidity</u> DUE TO (c) <u>degeneration</u> II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	
19a. DATE OF OPERATION <input checked="" type="checkbox"/>		19b. MAJOR FINDINGS OF OPERATION <input checked="" type="checkbox"/>	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21a. ACCIDENT SUICIDE HOMICIDE (Specify) <input checked="" type="checkbox"/>		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>Curryville</u>	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) <u>Pike Mo</u>
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) <u>10-23-50</u>		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR <input checked="" type="checkbox"/>
22. I hereby certify that I attended the deceased from <u>10-21</u> , 19 <u>50</u> , to <u>11-3</u> , 19 <u>50</u> , that I last saw the deceased alive on <u>10-23</u> , 19 <u>50</u> , and that death occurred at <u>1</u> m., from the causes and on the date stated above.			
23a. SIGNATURE <u>W. M. Mathews M.D.</u> (Degree or title)		23b. ADDRESS <u>Smiley Greenfield</u>	23c. DATE SIGNED <u>11-4-50</u>
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	24b. DATE <u>11-5-1950</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Curryville Cem.</u>	24d. LOCATION (City, town, or county) (State) <u>Curryville Mo.</u>
DATE REC'D BY LOCAL REG. <u>12/2/50</u>	REGISTRAR'S SIGNATURE <u>Bill Robinson</u>	25. FUNERAL DIRECTOR'S SIGNATURE (ADDRESS) <u>H. B. E. Moore Bashig Green</u>	

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

MAR 19 1957

SEP 18 1957

Date Received: DEC 8 1957
DISTRICT HEALTH OFFICE #2
District File Number 12-50-2081
Date Filed: DEC 11 1957

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.....

Student Embalmer No.

working under my personal supervision.

Student
Student Embalmer

Signed

H. B. E. Price

Licensed Embalmer No. *3466*

P. O. Address *Bostony Green*

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.