

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

FILED APR 28 1955

13895
State File No.
Registrar's No. 3500

BIRTH NO. _____ REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003

1. PLACE OF DEATH
a. COUNTY _____
2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Mo. b. COUNTY _____

b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis c. LENGTH OF STAY (In this place) _____
c. CITY OR TOWN St. Louis d. Is Residence within limits of a city or incorporated town? Yes No

d. FULL NAME OF HOSPITAL OR INSTITUTION 3861 Wyoming St. e. STREET ADDRESS (If rural, give location) 16 3861 Wyoming St. 21690

3. NAME OF DECEASED a. (First) CLARKE b. (Middle) B. c. (Last) SIBLEY 4. DATE OF DEATH (Month) (Day) (Year) Apr. 17 1955

5. SEX Male 6. COLOR OR RACE White 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widow 8. DATE OF BIRTH Sep. 23, 1878 9. AGE (In years last birthday) 76 If UNDER 1 YEAR Months Days If UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired insurance Agent 10b. KIND OF BUSINESS OR INDUSTRY Agent 11. BIRTHPLACE (City and State or Foreign Country) Springfield, Mo. 12. CITIZEN OF WHAT COUNTRY? U.S.A.

13a. FATHER'S NAME Frank Sibley 13b. MOTHER'S MAIDEN NAME Jeanette Barnhuist 14. NAME OF HUSBAND OR WIFE Late Lillian M. Sibley

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes 16. SOCIAL SECURITY NO. Span-Amer. War 17. INFORMANT'S SIGNATURE OR NAME ADDRESS Margaret Eller 3861 Wyoming St.

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, asthma, etc. It means the disease, injury, or complication which caused death. MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Arterio sclerotic heart ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Disease DUE TO (c) II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION _____ 19b. MAJOR FINDINGS OF OPERATION _____ 20. AUTOPSY? YES NO

21a. ACCIDENT SUICIDE HOMICIDE (Specify) _____ 21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) _____ 21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) _____ 21e. INJURY OCCURRED WHILE AT WORK NOT WHILE AT WORK 21f. HOW DID INJURY OCCUR? 4200

22. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at 300A m., from the causes and on the date stated above.

23a. SIGNATURE (Deceased or title) Robert E. Doyle 23b. ADDRESS 1700 Olive 23c. DATE SIGNED 4/18/55

24a. BURIAL, CREMATION, REMOVAL (Specify) Removal 24b. DATE Apr. 20, 1955 24c. NAME OF CEMETERY OR CREMATORY National Cemetery 24d. LOCATION (City, town, or county) (State) Jefferson Barracks, Mo.

DATE REC'D BY LOCAL REG. APR 19 1955 REGISTRAR'S SIGNATURE J. Carl Smith, M.D. 25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Kriegshauser 4228 S. Kingshighway Bl.

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

