

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

'57 0 27 57 9  
STATE FILE NUMBER

FILED AUG 19 1957

Registration District No. 42 Primary Registration District No. 1000 Registrar's No. 872

1. PLACE OF DEATH a. COUNTY <b>Buchanan</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>Buchanan</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>St. Joseph</b>		c. CITY OR TOWN <b>St. Joseph</b>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>St. Joseph's Hosp.</b>		d. STREET ADDRESS <b>2322 So. 13th</b>	
3. NAME OF DECEASED (Type or print) First <b>Richard</b> Middle <b>N</b> Last <b>Sisson</b>		4. DATE OF DEATH Month <b>Aug.</b> Day <b>11</b> Year <b>1957</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Jan. 6, 1900</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, spec if retired) <b>Ret. (1) Traveling Supt. Armour &amp; Co.</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Supt. Armour &amp; Co.</b>	11. BIRTHPLACE (City and state or country) <b>Buck, Okla.</b>
13. FATHER'S NAME <b>John Sisson</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>339-01-4205</b>	
17. INFORMANT <b>Mrs R.N. Sisson</b>		Address <b>2322 So. 13th City</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Multiple myeloma</b>			INTERVAL BETWEEN ONSET AND DEATH <b>1955</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> <b>2</b>
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>203x</b>		
20c. TIME OF INJURY Hour _____ Month _____ Day _____ Year _____ a. m. _____ p. m. _____			
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	
20f. CITY, TOWN, OR LOCATION		COUNTY STATE	
21. I attended the deceased from <b>1-9-57</b> to <b>8-11-57</b> and last saw <sup>her</sup> him alive on <b>8-10-57</b> Death occurred at <b>3:55 P</b> m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <b>M. H. Ames, M.D.</b> (Degree or title)		22b. ADDRESS <b>902 Edward St</b>	
22c. DATE SIGNED <b>8/12/57</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>Aug. 14, 1957</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Mt. Olivet Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>St. Joseph, Mo.</b>	
24. FUNERAL DIRECTOR <b>Herman W. Sederlader</b> ADDRESS <b>St. Joseph, Mo.</b>		25. DATE RECD. BY LOCAL REG. <b>Aug. 15, 1957</b>	
26. REGISTRAR'S SIGNATURE <b>Mrs. Robert Fulton</b>			

(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE. Coffin cannot certify to a death due to natural causes. Cause of death must be causally related. Cause of death must be causally related. Cause of death must be causally related.

MEDICAL CERTIFICATION

*Dr. Ames*

**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.....  
Signature of Student Embalmer

Signed *Robert H. Gaph*  
Licensed Embalmer No. 330

P. O. Address St. Joseph

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING.  
to comply with the above constitutes grounds for revocation of license).  
If embalmed by a STUDENT, he also shall sign in his OWN handwriting.  
If this body is not embalmed, fact should be so stated above.