

Health,
& Welfare
Public
Service

S. 300
1-57

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

39345

STATE FILE NUMBER

FILED NOV 18 1957

Registration District No. 42 Primary Registration District No. 1000 Registrar's No. 1214

1. PLACE OF DEATH a. COUNTY <u>Buchanan</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Buchanan</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>St. Joseph</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>St. Joseph</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>6003 Carnegie</u>		Length of stay in lb <u>47 years</u>	d. STREET ADDRESS (If outside, give location) <u>6003 Carnegie</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <u>Mary</u> Middle Last <u>Sidor</u>			4. DATE OF DEATH Month <u>Nov.</u> Day <u>6</u> Year <u>1957</u>		
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5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept. 25, 1895</u>	9. AGE (In years last birthday) <u>62</u>	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>Armour & Co.</u>	11. BIRTHPLACE (City and state or country) <u>Poland</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
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13a. FATHER'S NAME <u>Unk.</u>	13b. MOTHER'S MAIDEN NAME <u>Unk.</u>	14. NAME OF HUSBAND OR WIFE <u>Walter Sidor</u>
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15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>	16. SOCIAL SECURITY NO. <u>487-09-1796</u>	17. INFORMANT <u>Lawrence Sidor, St. Joseph, Mo</u> Address <u>4200</u>
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary Embolism</u>		INTERVAL BETWEEN ONSET AND DEATH <u>sudden</u>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <u>Arteriosclerotic Heart Disease</u>		<u>4 months</u>
	DUE TO (c) <u>Arteriosclerosis</u>		<u>unknown</u>
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"/>	

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.)
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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
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21. I attended the deceased from <u>March 9, 1953</u> to <u>Nov 6, 1957</u> and last saw <u>her</u> alive on <u>Oct 11, 1957</u> Death occurred at <u>6:AM</u> m on the date stated above; and to the best of my knowledge, from the causes stated.
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22a. SIGNATURE (Degree or title) <u>Sharon E. Waggoner M.D.</u>	22b. ADDRESS <u>301 Illinois Ave. St. Joseph, Mo</u>	22c. DATE SIGNED <u>11-8-57</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>11/8/57</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Mt. Olivet Cemetery</u>	23d. LOCATION (City, town, or county) (State) <u>St. Joseph, Mo:</u>
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24. FUNERAL DIRECTOR <u>John E. Stupp</u>	ADDRESS <u>St. Joseph, Mo</u>	25. DATE RECD. BY LOCAL REG. <u>Nov. 12, 1957</u>	26. REGISTRAR'S SIGNATURE <u>Mrs. Robert Fulton</u>
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(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related.

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JAN 23 1961

JAN 13 1958

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
Licensed Embalmer No.
P. O. Address

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.