

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

58-032986  
STATE FILE NUMBER

FILED SEP 16 1958 Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 4101

5. 300  
1-57

1. PLACE OF DEATH a. COUNTY <b>JACKSON</b>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MISSOURI</b> b. COUNTY <b>JACKSON</b>		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>KANSAS CITY</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <b>KANSAS CITY</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>VA HOSPITAL</b>		Length of stay in lb <b>40 YEARS</b>	d. STREET ADDRESS (If outside, give location) <b>6652 Bellefontaine</b>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) <b>GLEN</b> First <b>A.</b> Middle <b>SIDLE</b> Last			4. DATE OF DEATH <b>AUGUST 23 1958</b> Month <b>AUGUST</b> Day <b>23</b> Year <b>1958</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>July 17, 1908</b>	9. AGE (In years) <b>50</b> (at birthday) UNDER 1 YEAR: Months <input type="checkbox"/> Days <input type="checkbox"/> IF UNDER 24 HRS. Hours <input type="checkbox"/> Min. <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done or profession if retired) <b>Paint Salesman</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>SEIDLITZ PAINT CO.</b>		11. BIRTHPLACE (City and state or country) <b>DES MOINES, IAWA</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13a. FATHER'S NAME <b>EARL SIDLE</b>		13b. MOTHER'S MAIDEN NAME <b>BERTHA PETERSON</b>	
14. NAME OF HUSBAND OR WIFE <b>ORA L. SIDLE</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes or unknown) <b>Yes</b> (Date of discharge) <b>1-15-42 to 7-28-45</b>			
16. SOCIAL SECURITY NO. <b>495 03 6288</b>		17. INFORMANT Address <b>Official Records, VA Hospital, K.C. Mo.</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>Bronchopneumonia</b>					INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) <b>Bronchial carcinoma, R.L.L.</b>					19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)					
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.)		
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. Attended the deceased from <b>7-31-58</b> to <b>8-23-58</b>		Death occurred at <b>1:25</b> a.m. on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <i>J. A. Turner</i> (Degree or title)		22b. ADDRESS <b>MD V.A. Hospital, Kansas City, Mo</b>		22c. DATE SIGNED <b>8-23-58</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE <b>AUG-27-1958</b>		23c. NAME OF CEMETERY OR CREMATORY <b>NATIONAL CEMETERY</b>	
23d. LOCATION (City, town, or county) <b>FORT LEAVENWORTH, KANSAS</b>		(State)			
24. FUNERAL DIRECTOR <b>D.W. NEWCOMERS</b> ADDRESS <b>13318 1/2 CREEK BLVD SOOS-KANSAS CITY, MO.</b>		25. DATE RECD. BY LOCAL REG. <b>8-27-58</b>		26. REGISTRAR'S SIGNATURE <i>Neva Minshall</i>	

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.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

J. A. Turner

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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 ....., Student Embalmer No. .... working under my personal supervision.

Student .....  
Signature of Student Embalmer

Signed *W. P. Helton*

Licensed Embalmer No. 4421

P. O. Address KC. Mo.

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.