

Health,  
Welfare  
Public  
Service

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

59-000663  
STATE FILE NUMBER

FILED FEB 3 1959 Registration District No. 74 Primary Registration District No. 5298 Registrar's No. 6

300  
1-57

1. PLACE OF DEATH a. COUNTY <b>Clinton</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>Clinton</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Stewartsville</b>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	c. CITY OR TOWN <b>Stewartsville</b> <i>250</i>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION		Length of stay in lb <b>Life</b>	d. STREET ADDRESS (If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last <b>Harvey N. Sifers</b>			4. DATE OF DEATH Month Day Year <b>1/22/1959</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>7/17/1875</b>
9. AGE (In years last birthday) <b>83</b>		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) <b>Farmer</b>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) <b>Stewartsville, Mo.</b>
12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>		13a. FATHER'S NAME <b>William H. Sifers</b>	
13b. MOTHER'S MAIDEN NAME <b>Matilda Slaybaugh</b>		14. NAME OF HUSBAND OR WIFE <b>Mrs. Pearl Sifers</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>no</b>	17. INFORMANT Address <b>Mrs. Pearl Sifers, Stewartsville, 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>Arteriosclerotic Heart Disease</b> <b>&amp; Decompensation</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) <b>diarr</b>			INTERVAL BETWEEN ONSET AND DEATH <b>10 years</b>
20a. ACCIDENT SUICIDE HOMICIDE <input type="checkbox"/> <input type="checkbox"/> <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 <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>Nov 1958</b> to <b>Jan 22 1959</b> and last saw <sup>her</sup> alive on <b>Jan 19 1959</b> Death occurred at <b>1:15 pm</b> on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <b>A. Keenes M.D.</b>		22b. ADDRESS <b>Cameron, Mo</b>	22c. DATE SIGNED <b>1/24/59</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>1/25/59</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Independence, Cmty.</b>	23d. LOCATION (City, town, or county) (State) <b>Hempfle, Mo.</b>
24. FUNERAL DIRECTOR ADDRESS <b>W. F. Summerfield, Stewartsville, Mo.</b>		25. DATE RECD. BY LOCAL REG. <b>Mo. 1-26-59</b>	26. REGISTRAR'S SIGNATURE <b>Mary W. Scarce</b>

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

All diseases in Part I must be causally related.

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.E. Summerfield*

Licensed Embalmer No. *3007*  
P. O. Address *Stewartsville, TN*

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.