

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

61-012129
STATE FILE NUMBER

Registration District No. 317 Primary Registration District No. 541 Registrar's No. 604

AMENDED ↓

FILED VS MAR 14 1961

1. PLACE OF DEATH a. COUNTY <u>ST LOUIS</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MISSOURI</u> b. COUNTY <u>JEFFERSON</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>CLAYTON</u>	Length of stay in 1b <u>3 DAYS</u>	c. CITY OR TOWN <u>ARNOLD</u>	Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>ST LOUIS COUNTY Hosp.</u>		d. STREET ADDRESS (If outside, give location) <u>RT-2-Box 424</u>	Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <u>Patricia</u> Middle <u>ANN</u> Last <u>Sisco</u>			4. DATE OF DEATH Month <u>Feb.</u> Day <u>28</u> Year <u>1961</u>			
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>SEPT-18-1945</u>	9. AGE (last birthday) <u>15</u>	IF UNDER 1 YEAR Months <u>5</u> Days <u>10</u>	IF UNDER 24 HR Hours <u></u> Min. <u></u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HIGH SCHOOL STUDENT</u>		10b. KIND OF BUSINESS OR INDUSTRY <u></u>	11. BIRTHPLACE (City and state or country) <u>ST LOUIS Mo</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	

13a. FATHER'S NAME <u>ROBERT J. SISCO</u>		13b. MOTHER'S MAIDEN NAME <u>MAXINE BAKER</u>		14. NAME OF HUSBAND OR WIFE <u></u>	
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>NONE</u>		17. INFORMANT <u>ROBERT J. SISCO</u> Address <u>Rt 2-Box 424 ARNOLD Mo</u>	

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>Contusion of Brain Stem</u>		INTERVAL BETWEEN ONSET AND DEATH <u>60 hrs</u>
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)		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
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19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20a. ACCIDENT <input checked="" 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.) <u>Auto Accident</u>	
20c. TIME OF INJURY Hour <u>10:00 a.m.</u> Month, Day, Year <u>2-25-61</u>			

20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>Highway</u>	20f. CITY, TOWN, OR LOCATION <u>Lenny Ferry Rd. St. Louis Mo.</u>	COUNTY <u></u> STATE <u>Mo.</u>
21. I attended the deceased from <u>2-25-61</u> to <u>2-28-61</u> and last saw her alive on <u>2-28-61</u>		Death occurred at <u>11:00</u> <u>A.M.</u> on the date stated above, and to the best of my knowledge, from the causes stated.	

22a. SIGNATURE (Degree or title) <u>Robert J. Vorhies, M.D.</u>		22b. ADDRESS <u>601 S. Brentwood Clayton, Mo.</u>		22c. DATE SIGNED <u>2-28-61</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>REMOVAL</u>	23b. DATE <u>MAR-3-1961</u>	23c. NAME OF CEMETERY OR CREMATORY <u>ST FRANCIS MEMORIAL PARK</u>		23d. LOCATION (City, town, for county) (State) <u>BONNE TERRE, Mo</u>
24. FUNERAL DIRECTOR <u>Fey Funeral Home, MEHLVILLE Mo.</u>		25. DATE RECD. BY LOCAL REG. <u>3-2-61</u>	26. REGISTRAR'S SIGNATURE <u>John C. Murphy, M.D.</u>	

(Licensed Embalmer's Statement on Reverse Side)

DATE AMENDED

INSTEAD OF

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

ITEM NO. SHOULD READ

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 *Gustav W. Dieterle*

Licensed Embalmer No. 4329

P. O. Address St Louis 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.