

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-61-024492
STATE FILE NUMBER

Registration District No. 771 Primary Registration District No. 3012 Registrar's No. 78

AMENDED FILED AUG 15 1961

DATE AMENDED
INSTEAD OF
DOCUMENT
MEDICAL CERTIFICATION
BY AFFIDAVIT OF
ITEM NO. SHOULD READ

| | | | | | | | |
|--|----------------------------------|---|---|--|---|---|--|
| 1. PLACE OF DEATH a. COUNTY <u>Clay</u> | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Clay</u> | | | | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Excelsior Springs</u> | | Length of stay in 1b <u>Lifetime</u> | | c. CITY OR TOWN <u>Excelsior Springs</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>209 S. Frances St.</u> | | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | | d. STREET ADDRESS (If outside, give location) <u>209 S. Frances</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 <u>Alice</u> Last <u>Sisk</u> | | | 4. DATE OF DEATH Month <u>Aug.</u> Day <u>7</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 type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/> | | 8. DATE OF BIRTH <u>1-26-1873</u> | 9. AGE (last birthday) <u>88</u> IF UNDER 1 YEAR IF UNDER 24 HR Months Days Hours Min. | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>At home</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>None</u> | | 11. BIRTHPLACE (City and state or country) <u>Ray County, Mo.</u> | | 12. CITIZEN OF WHAT COUNTRY <u>USA</u> | |
| 13a. FATHER'S NAME <u>David McGuire</u> | | | 13b. MOTHER'S MAIDEN NAME <u>Ruth Ann O'Dell</u> | | 14. NAME OF HUSBAND OR WIFE <u>James. H. Sisk</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 Address <u>Mrs. Catherine McAfee, Ex. Springs, 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>mesenteric Thrombosis</u> DUE TO (b) <u>Embolism</u> DUE TO (c) <u>Arterio-sclerotic valvular heart dis. yrs</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Fall 4yrs ago. Compression of L₄</u> 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 | | | | | | | |
| 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.) | | | |
| 20c. TIME OF INJURY Hour _____ a.m. _____ p.m. Month, Day, Year _____ | | | | | | | |
| 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 <u>1951</u> to <u>7 Aug 61</u> and last saw her <u>alive</u> on <u>Aug 6, 1961</u> Death occurred at <u>2:30 p</u> m on the date stated above, and to the best of my knowledge, from the causes stated. | | | | | | | |
| 22a. SIGNATURE (Degree or title) <u>George E Sanders MD</u> | | | 22b. ADDRESS <u>Excelsior Springs, Mo.</u> | | 22c. DATE SIGNED <u>8-9-61</u> | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 23b. DATE <u>8-9-61</u> | 23c. NAME OF CEMETERY OR CREMATORY <u>New New Garden</u> | | 23d. LOCATION (City, town, or county) (State) <u>Excelsior Springs, Mo.</u> | | |
| 24. FUNERAL DIRECTOR ADDRESS <u>Prichard Funeral Home, Inc.</u> <u>Excelsior Springs, Missouri</u> | | | 25. DATE RECD. BY LOCAL REG. <u>8-11-61</u> | | 26. REGISTRAR'S SIGNATURE <u>Caroline Hutchings</u> | | |

(Licensed Embalmer's Statement on Reverse Side)

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 Ludley Jarman

Licensed Embalmer No. 4589

P. O. Address Excelsior Springs

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.