

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

**63-048657**  
STATE FILE NUMBER

Registration District No. 187 Primary Registration District No. 3040 Registrar's No. 282

DO NOT WRITE ON THIS STUB

VS 300 Rev. 4/59	AMENDED
1 <u>0595</u>	DATE AMENDED
2 <u>0580</u>	
3 <u>2</u>	
4 <u>0</u>	
5 <u>2</u>	
6	
7 <u>0</u>	
8 <u>2</u>	
9 <u>422.1</u>	
10	
11	
12 <u>86-0</u>	
13 <u>1-0</u>	

USE BLACK INK OR TYPEWRITER RIBBON	AMENDMENTS ON THIS RECORD ARE AS FOLLOWS
	INSTEAD OF
	DOCUMENT
	MEDICAL CERTIFICATION
	BY AFFIDAVIT OF
	ITEM NO. SHOULD READ

FILED DEC 24 1963

1. PLACE OF DEATH a. COUNTY <u>Linn</u>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Mo</u> b. COUNTY <u>Linn</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) <u>Chillicothe</u> Length of stay in 1b OR TOWN <u>3 yrs</u>		c. CITY OR TOWN <u>Browning</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>Susan's Rest Home</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside give location) Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>JAMES L SIDES</u>		4. DATE OF DEATH Month Day Year <u>12-11-1963</u>	
5. SEX <u>Male</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>2-14-1887</u>
9. AGE (last birthday) <u>76</u>		IF UNDER 1 YEAR Months Days	IF UNDER 24 HR Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Wright C Mo</u>	11. BIRTHPLACE (City and state or country) <u>USA</u>
12. CITIZEN OF WHAT COUNTRY <u>USA</u>		13. FATHER'S NAME <u>Crosby Sides</u>	
14. MOTHER'S MAIDEN NAME <u>Nancy Hoots</u>		15. NAME OF HUSBAND OR WIFE <u>Susan Fuller Sides</u>	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>World War I</u>		17. SOCIAL SECURITY NO. <u>[redacted]</u>	
18. CAUSE OF DEATH (Enter only one cause per line) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Chronic myocarditis</u> DUE TO (b) <u>arteriosclerosis</u> DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.		19. INTERVAL BETWEEN ONSET AND DEATH <u>?</u> <u>?</u>	
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	
20. 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		20g. COUNTY STATE	
21. I attended the deceased from <u>1962</u> to <u>Dec 11 '63</u> and last saw him alive on <u>Dec 8 '63</u> Death occurred at <u>11:05 PM</u> on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <u>Joseph F. Dale M.D.</u>		22b. ADDRESS <u>Chillicothe Mo</u>	
22c. DATE SIGNED <u>12-13-63</u>			
23a. BURIAL, CREMATION, OR REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>12-14-1963</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Heaven Cem.</u>	23d. LOCATION (City, town, or county) (State) <u>Browning Mo</u>
24. FUNERAL DIRECTOR <u>Rayne Funeral Home Salt Mo</u>		25. DATE RECD. BY LOCAL REG. <u>Dec 13, 1963</u>	
26. REGISTRAR'S SIGNATURE <u>Annalee Taylor</u>			

(Licensed Embalmer's Statement on Reverse Side)

STATE OF OHIO

DECEMBER 27 1963

DEC 27 1963

**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 *P. H. Payne Jr*

Licensed Embalmer No. 3400

P. O. Address Galt

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.