

260 FEB 23 1939

MISSOURI STATE BOARD OF HEALTH  
BUREAU OF VITAL STATISTICS  
CERTIFICATE OF DEATH

2441  
Do not use this space.

1. PLACE OF DEATH

(a) County Henry Registration District No. 347  
(b) Township Clinton Primary Registration District No. 3018 Registered No. \_\_\_\_\_  
(c) City \_\_\_\_\_ (d) Street No. \_\_\_\_\_  
(If death occurred in Hospital or Institution, write its name instead of street and number) St. \_\_\_\_\_  
(e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME

Infant of Mr + Mrs Robert Kisor  
(a) Residence, No. 919 South Washington St.  (If nonresident, give city or town and State)  
(Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED single  
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) \_\_\_\_\_  
7. AGE YEARS MONTHS DAYS If LESS than 1 day, \_\_\_\_\_ hrs. or \_\_\_\_\_ min.

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. \_\_\_\_\_  
9. Industry or business in which work was done, as saw mill, bank, etc. \_\_\_\_\_  
10. Date deceased last worked at this occupation (month and year) \_\_\_\_\_ 11. Total time (years) spent in this occupation \_\_\_\_\_

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Clinton Mo.

13. NAME Robert Kisor  
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Hartwell Mo.

15. MAIDEN NAME Millie Holsey  
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Clinton Mo.

17. INFORMANT (ADDRESS) Robert Kisor  
Clinton Mo.

18. BURIAL, CREMATION, OR REMOVAL PLACE Hartwell DATE 1-15-39

19. FUNERAL DIRECTOR (NAME) (ADDRESS) Conserv & Peers  
Clinton Mo.

20. FILED 1-28-39 Dr. J. R. Hampton Local Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY AND YEAR) 1-15-39  
22. I HEREBY CERTIFY, That I attended deceased from 1-15-39 to 1-15-39, 1939  
I last saw h. dead on 1-15-39, 1939. Death is said to have occurred on the date stated above, at \_\_\_\_\_ m.  
The principal cause of death and related causes of importance were as follows:

Still Born

Other contributory causes of importance:

Name of operation \_\_\_\_\_ Date of \_\_\_\_\_  
What test confirmed diagnosis? \_\_\_\_\_ Was there an autopsy? \_\_\_\_\_

23. If death was due to external causes (violence), fill in also the following:  
Accident, suicide, or homicide? \_\_\_\_\_ Date of injury \_\_\_\_\_, 19\_\_\_\_  
Where did injury occur? \_\_\_\_\_ (Specify city or town, county, and State)  
Specify whether injury occurred in industry, in home, or in public place.

Manner of injury \_\_\_\_\_  
Nature of injury \_\_\_\_\_

24. Was disease or injury in any way related to occupation of deceased? \_\_\_\_\_  
If so, specify \_\_\_\_\_  
(Signed) James O. Smith, M. D.  
Clinton Mo. (Address)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

RECEIVED

District Health Officer No. 7

District File Number 1-35-20

Date Filed 2-7-39

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.....

*Not Embalmed*....., Registered Apprentice No.....  
working under my personal supervision.

Signed

*J. E. Consolet*

Licensed Embalmer No. 1891

P. O. Address.....

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 this body is not embalmed, above space should be left blank.