WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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.

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

File No. 22151

PLACE OF DEATH

County Scott

Township Morley

or

Village

or

City (NO. St.; Ward)

Registration District No. 819

Primary Registration District No. 6068

Registered No. 4

[If death occurred in a hospital or institution, give its NAME instead of street and number]

FULL NAME James Richard Sittner

PERSONAL AND STATISTICAL PARTICULARS

SEX	COLOR OR RACE	SINGLE X MARRIED WIDOWED OR DIVORCED (Write the word)
Male	White	

DATE OF BIRTH April 5, 1917 (Month) (Day) (Year)

AGE 1 yrs. 2 mos. 9 ds. If LESS than 1 day, ...hrs. or ....min.?

OCCUPATION
(a) Trade, profession, or particular kind of work X none.
(b) General nature of industry, business, or establishment in which employed (or employer)

BIRTHPLACE (City or town, State or foreign country) Kelso - Tusp. Mo

PARENTS
NAME OF FATHER August Jesse Sittner
BIRTHPLACE OF FATHER (City or town, State or foreign country) Perry Co Mo
MAIDEN NAME OF MOTHER Gertrude Tuck.
BIRTHPLACE OF MOTHER (City or town, State or foreign country) Cape Co Mo--

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) August Jesse Sittner

(ADDRESS) Morley Mo

Filed June 1918 Mrs. J. M. Trisler REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH June 14, 1918 (Month) (Day) (Year)

I HEREBY CERTIFY, that I attended deceased from June 12, 1918, to June 14, 1918, that I last saw him alive on June 14, 1918, and that death occurred, on the date stated above, at 7 a.m.

The CAUSE OF DEATH* was as follows:

Entero Colitis

1178

104

(Duration) ....yrs. ....mos. ....ds.

Contributory X (SECONDARY)

(Duration) ....yrs. ....mos. ....ds.

(Signed) Ed. L. Harris M. D.

June 14, 1918 (Address) Morley Mo

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted if not at place of death?

Former or usual residence

PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Morley Cem.	June 15, 1918
UNDERTAKER	**ADDRESS**
C. D. M. Kuykendall	Morley Mo

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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.

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

PLACE OF DEATH

County.....

Township ..... Registration District No. ..... File No. .....

or

Village ..... Primary Registration District No. ..... Registered No. .....

or

City ..... (NO. ..... St.; ..... Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number]

FULL NAME .....

PERSONAL AND STATISTICAL PARTICULARS

SEX	COLOR OR RACE	SINGLE MARRIED WIDOWED OR DIVORCED (*Write* the word)

DATE OF BIRTH

..... (Month) ..... (Day), *1*..... (Year)

AGE ..... yrs. ..... mos. ..... ds.

If LESS than 1 day, ... hrs. or ..... min.?

OCCUPATION
(a) Trade, profession, or particular kind of work .....

(b) General nature of industry, business, or establishment in which employed (or employer) .....

BIRTHPLACE
(City or town, State or foreign country)

PARENTS

NAME OF FATHER

BIRTHPLACE OF FATHER
(City or town, State or foreign country)

MAIDEN NAME OF MOTHER

BIRTHPLACE OF MOTHER
(City or town, State or foreign country)

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) .....

(ADDRESS) .....

Filed ....., 191...., ...

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH

..... (Month) ..... (Day), *191*..... (Year)

I HEREBY CERTIFY, that I attended deceased from ....., 191...., to ....., 191...., that I last saw h..... alive on ....., 191...., and that death occurred, on the date stated above, at ..... m.

The CAUSE OF DEATH* was as follows:

.....

.....

.....

..... (Duration) ..... yrs. ..... mos. ..... ds.

Contributory (SECONDARY) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) ..... M. D.

....., 191.... (Address) .....

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted if not at place of death? .....

Former or usual residence .....

PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL ....., 191....
UNDERTAKER	ADDRESS