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

1 PLACE OF DEATH

County Jasper

Township or Village or City Carterville (NO. 304 S. Pearl St.; Ward)

Registration District No. 407 File No. 1818

Primary Registration District No. 4241 Registered No. 10

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

2 FULL NAME Joseph S. Sitter

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male

4 COLOR OR RACE White

5 SINGLE MARRIED WIDOWED OR DIVORCED (Write the word) Married

6 DATE OF BIRTH July (Month) 13 (Day) 1 (Year)

7 AGE 35 yrs. 6 mos. 17 ds.

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

8 OCCUPATION
(a) Trade, profession, or particular kind of work Miner
(b) General nature of industry business or establishment in which employed (or employer) Lead & Zink

9 BIRTHPLACE (City or town, State or foreign country) Jasper Co. Mo.

PARENTS

10 NAME OF FATHER J. N. Sitter

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

12 MAIDEN NAME OF MOTHER Nancy Bishop

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

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs Hill Haywoth

(Address) Granby Mo.

15

Filed 2/8, 1919 J. R. Barry Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Jan. (Month) 31 (Day) 1919 (Year)

17 I HEREBY CERTIFY, that I attended deceased from Jan 30, 1919, to Jan 30, 1919, that I last saw him alive on Jan 30, 1919, and that death occurred, on the date stated above, at 3:30 a.m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

23A 28

(Duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) R. M. Stormont M. D.

Feb 1, 1919 (Address) Carterville

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

18 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

19 PLACE OF BURIAL OR REMOVAL Carterville Cem. DATE OF BURIAL Feb 1st 1919

20 UNDERTAKER Webb City Mfg Co ADDRESS Webb City

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

1 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.]

2 FULL NAME .....

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 SINGLE MARRIED WIDOWED OR DIVORCED (*Write* the word)

6 DATE OF BIRTH

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

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

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

8 OCCUPATION
(a) Trade, profession, or particular kind of work .....
(b) General nature of industry business, or establishment in which employed (or employer) .....

9 BIRTHPLACE (City or town, State or foreign country)

PARENTS

10 NAME OF FATHER

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

12 MAIDEN NAME OF MOTHER

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

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) .....

(Address) .....

15

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

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

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

17 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.

18 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 .....

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL ..... , 191.....

20 UNDERTAKER

ADDRESS