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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED MAR 9 1942

Registration District No. 347

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

Primary Registration District No. 5485

State File No. 6764

Registrar's No.

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH

(a) County: Henry

(b) City or town: Rural Bogard
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: /
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution ____ (Specify whether)
In this community (years, months or days): 65 years

2. USUAL RESIDENCE OF DECEASED:

(a) State: Mo. (b) County: Henry

(c) City or town: Rural
(If outside city or town limits, write "RURAL")

(d) Street No. ____
(If rural, give location)

(e) If foreign born, how long in U. S. A.? 88 years

3. (a) PRINT FULL NAME: Christopher Conrad Sites

3. (b) If veteran, name war ____ 3. (c) Social Security No. ✓

4. Sex: Male 5. Color or race: White 6. (a) Single, married, widowed, divorced: Widowed

6. (b) Name of husband or wife: Dead 6. (c) Age of husband or wife if alive ____ years

7. Birth date of deceased: Jan. (Month) 3 (Day) 1853 (Year)

8. AGE: Years 89 Months 11 Days 3 If less than one day ____ hr. ____ min.

9. Birthplace: Germany (City, town, or county) (State or foreign country)

10. Usual occupation: Farmer

11. Industry or business ____

FATHER
12. Name: John Sites
13. Birthplace: Germany (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name: Unknown
15. Birthplace ____ (City, town, or county) (State or foreign country)

16. (a) Informant: John B. Sites
(b) Address: Creighton Mo.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof: Jan 21 1942 (Month) (Day) (Year)
(c) Place: burial or cremation: Hendrix Cemetery

18. (a) Signature of funeral director: Robert Arnold
(b) Address: Creighton Mo.

19. (a) Feb. 13, 1942 (Date received by local registrar) (b) Georgia Kitchen (Registrar's signature) D.K.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan day 21 year 1942 hour 1:30 minute ____ A.M.

21. I hereby certify that I attended the deceased from Jan 10 1942 to Jan 21 1942 that I last saw him alive on Jan 20 1942 and that death occurred on the date and hour stated above.

Immediate cause of death: Pneumonia / Duration 10 days

Due to: ____

Due to: ____

Other conditions (Include pregnancy within 3 months of death): Senility

Major findings:
Of operations: ____
Of autopsy: ____

PHYSICIAN — Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify): ____
(b) Date of occurrence: ____
(c) Where did injury occur? ____ (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? ____
While at work? ____ (Specify type of place) (e) Means of injury: ____

23. Signature: J W Galbraith (M. D. or other)
Address: Ulrich Mo Date signed 12/1/42

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Officer No. 7,
District File Number 3-42-174
Date Filed 3-4-42

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 _____, Registered Apprentice No. _____, working under my personal supervision.

Signed Hobart Arnold

Licensed Embalmer No. 3621

P. O. Address Creighton, Mo.

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.

No. 2B
—8-21-41
I X29288

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 6764

Registration District No. 347 Primary Registration District No. Registrar's No.

1. PLACE OF DEATH:
(a) County Henry
(b) City or town Rural
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution (Specify whether years, months or days)
In this community

2. USUAL RESIDENCE OF DECEASED:
(a) State (b) County
(c) City or town
(If outside city or town limits, write "RURAL")
(d) Street No.
(If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME Christopher C. Sites

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex M

5. Color or race W

6. (a) Single, widowed, married, divorced W

6. (b) Name of husband or wife

6. (c) Age of husband or wife if alive years

7. Birth date of deceased Jan 3 1853
(Month) (Day) (Year)

8. AGE: Years 89 Months 11 Days If less than one day hr. min.

9. Birthplace (City, town, or county) (State or foreign country)

10. Usual occupation

11. Industry or business

MOTHER FATHER
12. Name
13. Birthplace (City, town, or county) (State or foreign country)
14. Maiden name
15. Birthplace (City, town, or county) (State or foreign country)

16. (a) Informant
(b) Address

17. (a) (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)
(c) Place: burial or cremation

18. (a) Signature of funeral director
(b) Address

19. (a) (Date received local registrar) (b) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan Day 21 year 1942 hour minute M.

21. I hereby certify that I attended the deceased from 19 to 19; that I last saw h alive on 19; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Pneumonia	
Due to Bronchial	
Due to	
Other conditions (Include pregnancy within 3 months of death)	
Major findings: Of operations	
Of autopsy	

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify)
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(b) Did injury occur in or about home, on farm, in industrial place, in public place?
While at work? (Specify type of place) (e) Means of injury

23. Signature (M. D. or other)
Address Date signed

SUPPLEMENTARY