DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED MAR 1 1943

Registration District No. 10

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

Primary Registration District No. 3002

5700

State File No.

Registrar's No. 26

1. PLACE OF DEATH:

(a) County: Audrain

(b) City or town: Mexico Mo.
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: Audrain Co. Hospital
(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: Missouri (b) County: Montgomery

(c) City or town: 0
(If outside city or town limits, write "RURAL")

(d) Street No.: 0
(If rural, give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country: /

3. (a) PRINT FULL NAME: MRS. SUSIE B. (BRINKMAN) SITTON

3. (b) If veteran, name war:

3. (c) Social Security No.: none.

4. Sex: Female

5. Color or race: White

6. (a) Single, widowed, married, divorced: Married

6. (b) Name of husband or wife:

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

7. Birth date of deceased: November (Month) - 4 (Day) - 1880 (Year)

8. AGE: Years 62 Months 3 Days 12 If less than one day hr. min.

9. Birthplace: Lincoln Co. (City, town, or county) Mo. 0 (State or foreign country)

10. Usual occupation: House wife

11. Industry or business: None

FATHER
12. Name: W. A. Odem
13. Birthplace: D. N. (City, town, or county) 9 (State or foreign country)

MOTHER
14. Maiden name: D. N.
15. Birthplace: D. N. (City, town, or county) 9 (State or foreign country)

16. (a) Informant: Jean Brinkman
(b) Address: 2736 Charlotte - K.C. Mo.

17. (a) Buried (Burial, cremation, or removal) (b) Date thereof: Feb. 18-1943 (Month) (Day) (Year)

(c) Place: burial ~~or cremation~~ Mexico Mo.

18. (a) Signature of funeral director: Washington Bros.
(b) Address: Mexico Mo.

19. (a) Feb 17-1943 (Date received local registrar) (b) Margaret H Mack (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb day 16 year 1943 hour 11 minute 10 A.M.

21. I hereby certify that I attended the deceased from 2-13-1943 to 2-16-1943 that I last saw him alive on 2-16-1943 and that death occurred on the date and hour stated above.

Immediate cause of death	Duration
Diabetes	
Lobar pneumonia	
Due to	
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)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? (Specify type of place)

While at work? (e) Means of injury

23. Signature: James C. Kelley (M. D. or other) MD

Address: Mexico, Mo. Date signed: 2/17/43

1074 (Licensed Embalmer's Statement on Reverse Side)

MAR 1 1943

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 Roy A. McPhe

Licensed Embalmer No. 1133

P. O. Address .....

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.

No. 2B
8-21-41
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. 6 700

Registration District No. 10 Primary Registration District No. 3002 Registrar's No. 26

1. PLACE OF DEATH:
(a) County: Andrain
(b) City or town: mexico (If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Andrain Co. Hosp. (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: Missouri (b) County: Montgomery
(c) City or town: Big Spring (If outside city or town limits, write "RURAL")
(d) Street No. ..... (If rural, give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country .....

3. (a) PRINT FULL NAME: Susie B. Sitton
3. (b) If veteran, name war .....
3. (c) Social Security No. .....
4. Sex: F
5. Color or race: W
6. (a) Single, widowed, married, divorced: m
6. (b) Name of husband or wife .....
6. (c) Age of husband or wife if alive ..... years
7. Birth date of deceased: Nov. 7, 1880 (Month) (Day) (Year)
8. AGE: Years 62 Months 3 Days 18 If less than one day ..... hr. ..... min.
9. Birthplace: Mo. (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) Margaret H Macke (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb. 6 year 1943 hour ..... minute ..... M.
21. I hereby certify that I attended the deceased from ..... 19..... to ..... 19.....; that I last saw him alive on ..... 19.....; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death	
Due to	
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)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? ..... (Specify type of place)
While at work? ..... (e) Means of injury .....
23. Signature ..... (M. D. or other) .....
Address ..... Date signed .....

SUPPLEMENTARY