

S. No. 2
M-843
7. 5-17-39
X37823

FILED FEB 11 1947

Registration District No. 1 Primary Registration District No. 5429 Registrar's No. 1

1. PLACE OF DEATH:
 (a) County Franklin
 (b) City or town Rural Lyon
 (c) Name of hospital or institution: 1
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution (Specify whether)
 In this community Not known years, months or days

3. (a) PRINT FULL NAME Reake Sitterman
 (b) If veteran, name war: _____ (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 William Sitterman 6. (c) Age of husband or wife if alive 73 years
 7. Birth date of deceased Feb 2 1867
 (Month) (Day) (Year)

8. AGE: Years 79 Months 11 Days 2 If less than one day hr. _____ min. _____

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

10. Usual occupation Homemaker

11. Industry or business _____

12. Name William Bockermann

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

14. Maiden name Therese Klindt

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

16. (a) Informant William Sitterman

(b) Address Sherald Mo Route 2

17. (a) Burial (b) Date thereof Jan 7 1947
 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Leslie Mo

18. (a) Signature of funeral director: E. H. Lemme

(b) Address Beaufort Mo

19. (a) 1-6-47 (b) H. Mauerwa
 (Date received local registrar) (Registrar's signature)

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month JAN day 4th
 year 47 hour 2:00 minute — P.M.
 21. I hereby certify that I attended the deceased from 1 JAN 47
 _____, 19____, to 4 JAN, 1947

that I last saw her alive on 3 JAN 47, 19____; and that death occurred on the date and hour stated above.

Immediate cause of death Pneumonia lobes Duration 7 days
Bilateral

Due to Type of organism (undetermined)

Due to _____

Other conditions Myocarditis, chronic
 (Include pregnancy within 3 months of death)
MITRAL INSUFFICIENCY

Major findings: None **PHYSICIAN**
 Of operations _____

Of autopsy None 92 B
 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 B. J. Macaulay (M. D. or other) 0

Address Sherald Mo Date signed 7 JAN 47

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

MOTHER FATHER

Date Filed 2-10-47

District File Number

District Health Officer No.

RECEIVED

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.....

E. H. Jenne

working under my personal supervision.

Registered Apprentice No.....

Signed *E. H. Jenne*

Licensed Embalmer No. 3076

P. O. Address Beaufort 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, fact should be so stated above.