

FILED JAN 11 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

1037

State File No. _____

BIRTH NO. 128		REG. DIST. NO. 128		PRIMARY REG. DIST. NO. 5465		Registrar's No. 1137	
1. PLACE OF DEATH a. COUNTY <u>Greene</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>Greene</u>			
b. CITY OR TOWN <u>Rural, Rt. 5, Springfield</u>		c. LENGTH OF STAY (in this place) <u>3 yrs.</u>		c. CITY OR TOWN <u>Rural Rt 5, Springfield</u>			
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>1</u>				d. STREET ADDRESS (If rural, give location) <u>Rt #5</u>			
3. NAME OF DECEASED (Type or Print) a. (First) <u>MARY</u>			b. (Middle) <u>NANCY</u>		c. (Last) <u>Sitze</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>1 1 49</u>
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>widowed</u>		8. DATE OF BIRTH <u>12/28/1869</u>	9. AGE (in years last birthday) <u>80</u>	IF UNDER 1 YEAR Months <u>0</u> Days <u>4</u>	IF UNDER 6 MRS. Hours <u></u> Mins. <u></u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Fainsville, Mo.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13a. FATHER'S NAME <u>John Bailey</u>			13b. MOTHER'S MAIDEN NAME <u>MARY ELLEN BARNARD</u>		14. NAME OF HUSBAND OR WIFE <u>William Oliver Sitze</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. _____		17. INFORMANT'S SIGNATURE OR NAME <u>Vie Sitze</u> ADDRESS <u>Rt 5 Springfield</u>			
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). *This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death. <u>108</u>	MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Lobar Pneumonia</u> ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Respiratory Failure</u> DUE TO (c) <u>Decompensated Acute Cor Pulmonale.</u> II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>Chronic Bronchitis.</u> INTERVAL BETWEEN ONSET AND DEATH <u>10 days</u>						
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION <u>HU</u>					20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT SUICIDE HOMICIDE (Specify)		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21c. (CITY, TOWN, OR TOWNSHIP) _____ (COUNTY) _____ (STATE) _____			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) _____ m.		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Dec 29, 1948</u> , to <u>Jan 1, 1949</u> , that I last saw the deceased alive on <u>Jan 1, 1949</u> , and that death occurred at <u>9:45 P.m.</u> , from the causes and on the date stated above.							
23a. SIGNATURE (Degree or title) <u>Dr. D. F. Ewell</u>			23b. ADDRESS <u>234 1/2 Commercial</u>			23c. DATE SIGNED <u>1-3-49</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		24b. DATE <u>1/4/49</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Panther Valley</u>		24d. LOCATION (City, town, or county) <u>Webster</u> (State) <u>Mo.</u>		
DATE RECD BY LOCAL REG.		REGISTRAR'S SIGNATURE <u>W. E. Skindley</u>			25. FUNERAL DIRECTOR'S SIGNATURE <u>Kelley-Ferrill-Berman</u> ADDRESS <u>Fardland</u>		

(Licensed Embalmer's Statement on Reverse Side)

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

39
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JAN 14 1948

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.....

..... Student Embalmer No.

working under my personal supervision.

Signed H. H. Kelley.....

Signed.....

Student Embalmer

Licensed Embalmer No. 38334.....

P. O. Address Fordland, Maine.....

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.