No. 300
10-48

FILED SEP 7 1954

# THE DIVISION OF HEALTH OF MISSOURI
# STANDARD CERTIFICATE OF DEATH

28668

State File No. .....

BIRTH NO. _____ REG. DIST. NO. 310 PRIMARY REG. DIST. NO. 3058 Registrar's No. 181

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

**1. PLACE OF DEATH**
a. COUNTY St. Charles
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) St. Charles
c. LENGTH OF STAY (In this place) 6 Hrs.
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) St. Josephs Hospital

**2. USUAL RESIDENCE** (Where deceased lived. If institution: residence before admission).
a. STATE Missouri
b. COUNTY St. Louis
c. CITY OR TOWN Robertson
d. Is Residence within limits of a city or incorporated town? Yes ☐ No ☒
e. STREET ADDRESS (If rural, give location) Rt 2 Box 91 4000

**3. NAME OF DECEASED** (Type or Print)
a. (First) John
b. (Middle) J.
c. (Last) Litteken

**4. DATE OF DEATH** (Month) (Day) (Year) Aug 30 1954

**5. SEX** Male
**6. COLOR OR RACE** White
**7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED** (Specify) Widowed
**8. DATE OF BIRTH** May 10 1858
**9. AGE** (In years last birthday) 96 — If under 1 year: Months / Days — If under 24 hrs.: Hours / Min.

**10a. USUAL OCCUPATION** (Give kind of work done during most of working life, even if retired) Retired Farmer
**10b. KIND OF BUSINESS OR INDUSTRY** Farming
**11. BIRTHPLACE** (City and State or Foreign Country) Illinois
**12. CITIZEN OF WHAT COUNTRY?** U.S.A.

**13a. FATHER'S NAME** Joseph Litteken
**13b. MOTHER'S MAIDEN NAME** Unknown
**14. NAME OF HUSBAND OR WIFE** The Late Anna Litteken

**15. WAS DECEASED EVER IN U.S. ARMED FORCES?** (Yes, no, or unknown) No (If yes, give war or dates of service) No
**16. SOCIAL SECURITY NO.** None
**17. INFORMANT'S SIGNATURE OR NAME** Joseph Litteken Rt 2 Box 91 ADDRESS Robertson

**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, asthenia, etc. It means the disease, injury, or complication which caused death.

**MEDICAL CERTIFICATION**

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) | Lobar pneumonia | 3 days |
| ANTECEDENT CAUSES — Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) | Fracture Lt Hip | 6 wks |
| DUE TO (c) | | |
| II. OTHER SIGNIFICANT CONDITIONS — Conditions contributing to the death but not related to the disease or condition causing death. | generalized arteriosclerosis | 15 yrs ? |

**19a. DATE OF OPERATION**
**19b. MAJOR FINDINGS OF OPERATION** E9049 45
**20. AUTOPSY?** YES ☐ NO ☒

**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) 40C

**21d. TIME OF INJURY** (Month) (Day) (Year) (Hour) m.
**21e. INJURY OCCURRED** WHILE AT WORK ☐ NOT WHILE AT WORK ☐
**21f. HOW DID INJURY OCCUR?**

22. *I hereby certify that I attended the deceased from* August 29, 1954, *to* August 30, 1954, *that I last saw the deceased alive on* August 30, 1954, *and that death occurred at* 9 P *m., from the causes and on the date stated above.*

**23a. SIGNATURE** George E Kister (Degree or title) Md C
**23b. ADDRESS** St. Charles Mo
**23c. DATE SIGNED** 9-1-54

**24a. BURIAL, CREMATION, REMOVAL** (Specify) Burial
**24b. DATE** Sept 3 1954
**24c. NAME OF CEMETERY OR CREMATORY** Sacred Heart Cemetery
**24d. LOCATION** (City, town, or county) Florissant (State) Mo.

**DATE REC'D BY LOCAL REG.** Sept 1 1954
**REGISTRAR'S SIGNATURE** Fannie Hamilton 284-0
**25. FUNERAL DIRECTOR'S SIGNATURE** Collier Mortuary 10123 ADDRESS St. Chas. Rd St. Louis Missouri

(Licensed Embalmer's Statement on Reverse Side)

## STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was emba

by me, or by ....., Student Embalmer No.....

working under my personal supervision..

Student.....
Signature of Student Embalmer

Signed [illegible]

Licensed Embalmer No. [illegible]

P. O. Address [illegible]

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

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

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