

FILED APR 25 1955

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **11245**

BIRTH NO. _____ REG. DIST. NO. **53** PRIMARY REG. DIST. NO. **3010** Registrar's No. **190**

1. PLACE OF DEATH a. COUNTY CAPE		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY SCOTT	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN CAPE GIRARDEAU		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN CHAFFEE	
c. LENGTH OF STAY (in this place) 2 1/2 WKS		d. STREET ADDRESS (If rural, give location) 432 BLACK AVE. 100/1	
d. FULL NAME OF HOSPITAL OR INSTITUTION ST. FRANCIS HOSPITAL			

3. NAME OF DECEASED (Type or Print)	a. (First) LOUIS	b. (Middle) AUGUSTA	c. (Last) LITZLER	4. DATE OF DEATH (Month) (Day) (Year) APR. 20, 1955
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5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) MARRIED	8. DATE OF BIRTH JAN. 23, 1871	9. AGE (In years last birthday) 84 IF UNDER 1 YEAR Months 2 Days 27 IF UNDER 24 HRS. Hours Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FARMER (RET.)	10b. KIND OF BUSINESS OR INDUSTRY FARMING	11. BIRTHPLACE (State or foreign country) HAUBSTADT, INDIANA	12. CITIZEN OF WHAT COUNTRY? U.S.A.
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13a. FATHER'S NAME CONRAD LITZLER	13b. MOTHER'S MAIDEN NAME CATHERINE (Unknown)	14. NAME OF HUSBAND OR WIFE ANNA BELL LITZLER
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO	16. SOCIAL SECURITY NO. NONE	17. INFORMANT'S SIGNATURE OR NAME ADDRESS MRS. ANNA B. LITZLER - CHAFFEE, Mo.
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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.	1. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cardio-renal-Vascular disease		INTERVAL BETWEEN ONSET AND DEATH 20 days
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____		
	II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. DUE TO (c) _____		

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION 442X	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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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)	21e. INJURY OCCURRED WHILE AT WORK <input checked="" type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from **4/2**, 19**55**, to **4 20**, 19**55**, that I last saw the deceased alive on **4 20**, 19**55**, and that death occurred at **3 0** m., from the causes and on the date stated above.

23a. SIGNATURE W. Ashley MD	23b. ADDRESS Cape Girardeau Mo	23c. DATE SIGNED 4-20-55
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24a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	24b. DATE 4-23-1955	24c. NAME OF CEMETERY OR CREMATOR DEXTER CEMETERY	24d. LOCATION (City, town, or county) (State) DEXTER, MISSOURI
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DATE REC'D BY LOCAL REG. 4-21-55	REGISTRAR'S SIGNATURE W. C. Summers	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS W. C. Summers - Chaffee, Mo.
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

APR 29 1967 HJH

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.

Student _____
Student Embalmer

Signed _____

Jack J. Burnett

Licensed Embalmer No. _____

4472

P. O. Address _____

Chaffee, Missouri

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.