

FILED OCT 11 1955

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

29152

State File No.

BIRTH NO. _____ REG. DIST. NO. 47 PRIMARY REG. DIST. NO. 3008 Registrar's No. 256

1. PLACE OF DEATH a. COUNTY <u>Callaway</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Mo</u> b. COUNTY <u>Wite</u>	
b. CITY OR TOWN <u>Fulton</u>	c. LENGTH OF STAY (If this place) <u>5 days</u>	c. CITY OR TOWN <u>R.R Clarksville</u>	d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input type="checkbox"/>
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>State Hospital No 1</u>		e. STREET ADDRESS (If rural, give location) <u>Unit</u>	

3. NAME OF DECEASED (Type or Print) a. (First) <u>RHODA</u> b. (Middle) <u>Frances</u> c. (Last) <u>SITTON</u>			4. DATE OF DEATH (Month) (Day) (Year) <u>Sept 24 1955</u>		
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>28 March 1875</u>	9. AGE (In years last birthday) <u>80</u>	10. <u>5</u> 11. <u>26</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House work</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>		11. BIRTHPLACE (City and State or Foreign Country) <u>Mo</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>					

13a. FATHER'S NAME <u>F.C. Sitton</u>		13b. MOTHER'S MAIDEN NAME <u>Mary Jane Kirk Hart</u>		14. NAME OF HUSBAND OR WIFE <u>Unit</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>Unit</u>		16. SOCIAL SECURITY NO. <u>Unit</u>		17. INFORMANT'S SIGNATURE OR NAME <u>State Hospital No 1</u> ADDRESS <u>Fulton, Mo</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, ashenia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH <u>one day</u>
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Cerebral arterio sclerosis</u>		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>(Parkinsons Disease)</u> DUE TO (c) <u>350XF</u>		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>1 Broncho pneumonia</u> <u>2 Arterio sclerosis degenerative.</u>			

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION <u>Fracture of Hip - 12 Sept 1955</u>	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21a. ACCIDENT SUICIDE HOMICIDE (Specify) <u>Accident</u>	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>Home</u>	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) <u>R.R Clarksville Wite Mo</u>
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) <u>Sept 12 1955 A.M.</u>	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	21f. HOW DID INJURY OCCUR? <u>I do not know</u>

22. I hereby certify that I attended the deceased from 19 Sept 1955, to 24 Sept 1955, that I last saw the deceased alive on 24 Sept 1955, and that death occurred at 2:00 p.m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) <u>S.S. Woracich M.D.</u>	23b. ADDRESS <u>Fulton, Mo</u>	23c. DATE SIGNED <u>24 Sept 1955</u>
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	24b. DATE <u>Sept 24/55</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Greenwood</u>
24d. LOCATION (City, town, or county) (State) <u>CLARKSVILLE Mo</u>		

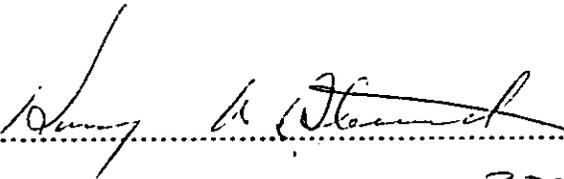
DATE REC'D BY LOCAL REG. <u>Oct. 3 - 1955</u>	REGISTRAR'S SIGNATURE <u>Martha Lawrence</u>	426	25. FUNERAL DIRECTOR'S SIGNATURE <u>Maupins Funeral Home</u> ADDRESS <u>Fulton</u>
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

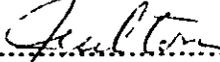
STATEMENT BY LICENSED EMBALMER

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.....
Signature of Student Embalmer

Signed 

Licensed Embalmer No. 327.....

P. O. Address 

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 embalmed by a STUDENT, he also shall sign, in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.