

FILED JAN 4 - 1956

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **40067**

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. **87** PRIMARY REG. DIST. NO. **4565** Registrar's No. **11**

1. PLACE OF DEATH a. COUNTY <b>Crawford</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <b>Mo</b> b. COUNTY <b>Crawford</b>	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>Sullivan-Boone</b>		c. CITY OR TOWN <b>Sullivan</b>	d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input type="checkbox"/>
c. LENGTH OF STAY (in this place) <b>48yr</b>		e. STREET ADDRESS (If rural, give location) <b>621 Dunigan</b>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>621 Dunigan</b>			
3. NAME OF DECEASED (Type or Print) a. (First) <b>Louise</b> b. (Middle) <b>Josephine</b> c. (Last) <b>Hittl</b>		4. DATE OF DEATH (Month) (Day) (Year) <b>12 30 1955</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>Widow</b>	8. DATE OF BIRTH <b>8-9-1871</b>
9. AGE (In years last birthday) <b>84</b>		IF UNDER 1 YEAR Months <b>4</b>	IF UNDER 4 HRS. Hours <b>21</b> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>	11. BIRTHPLACE (City and State or Foreign Country) <b>Germany</b>
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
13a. FATHER'S NAME <b>John Wenerwoser</b>		13b. MOTHER'S MAIDEN NAME <b>Unknown</b>	14. NAME OF HUSBAND OR WIFE <b>John A Hittl</b>
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>No</b>	17. INFORMANT'S SIGNATURE OR NAME <b>John Hittl</b> ADDRESS <b>Sullivan Mo</b>
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.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Cerebral Hemorrhage</b> INTERVAL BETWEEN ONSET AND DEATH <b>2 weeks</b>  ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____  II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <b>331X</b>	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
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)		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 <b>Dec 17, 1955</b> , to <b>Dec 30, 1955</b> , that I last saw the deceased alive on <b>Dec 29, 1955</b> , and that death occurred at <b>2:30 A. m.</b> , from the causes and on the date stated above.			
23a. SIGNATURE (Degree or title) <b>Ronald K. Scott D.O.</b>		23b. ADDRESS <b>Sullivan Missouri</b>	
23c. DATE SIGNED <b>12-30-55</b>			
24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		24b. DATE <b>1-2-1956</b>	
24c. NAME OF CEMETERY OR CREMATORY <b>St. Anthony's Cemetery</b>		24d. LOCATION (City, town, or county) (State) <b>Sullivan Mo</b>	
DATE REC'D BY LOCAL REGISTRAR'S SIGNATURE <b>12-30-55</b>		25. FUNERAL DIRECTOR'S SIGNATURE <b>Thos P Shaffer</b> ADDRESS <b>Sullivan Mo</b>	

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

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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 me....., Student Embalmer No..... working under my personal supervision..

Student.....  
Signature of Student Embalmer

Signed Paul F. Knollenberg.....

Licensed Embalmer No. 263.....

P. O. Address Sullivan.....

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.