

FEB 25 1957

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

5892

State File No.

BIRTH NO. _____		REG. DIST. NO. <u>310</u>		PRIMARY REG. DIST. NO. <u>3058</u>		Registrar's No. <u>75</u>	
1. PLACE OF DEATH a. COUNTY <u>St. Charles</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u> COUNTY <u>St. Louis</u>			
b. CITY (If outside corporate limits, write RURAL and give township) <u>St. Charles</u>		c. LENGTH OF STAY (In this place) <u>2 Weeks</u>		c. CITY OR TOWN <u>Robertson</u>		d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> # _____	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>St. Josephs Hospital</u>				STREET ADDRESS (If rural, give location) <u>Rt. 3 Box 235 Robertson Mo.</u>			
3. NAME OF DECEASED (Type or Print)		a. (First) <u>George</u>		b. (Middle) <u>H.</u>		c. (Last) <u>Litteken</u>	
4. DATE OF DEATH		(Month) <u>Feb.</u>		(Day) <u>24,</u>		(Year) <u>1957</u>	
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED. NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Single</u>		8. DATE OF BIRTH <u>April 13 1894</u>	
9. AGE (In years last birthday) <u>62</u>		IF UNDER 1 YEAR Months _____		IF UNDER 1 YEAR Days _____		IF UNDER 14 HRS. Hours _____ Min. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farming</u>		11. BIRTHPLACE (City and State or Foreign Country) <u>Florissant Mo.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13a. FATHER'S NAME <u>John J. Litteken</u>			13b. MOTHER'S MAIDEN NAME <u>Johanna Kopperschmidt</u>			14. NAME OF HUSBAND OR WIFE <u>Single</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <u>Yes W.W. I</u>		16. SOCIAL SECURITY NO. <u>794-42-3679</u>		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>Alphonse Litteken, Robertson 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, asthma, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Duodenal ulcer</u> ANTECEDENT CAUSES <u>Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.</u> DUE TO (b) <u>Past operative acute pancreatitis</u> DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS <u>Conditions contributing to the death but not related to the disease or condition causing death.</u>				INTERVAL BETWEEN ONSET AND DEATH <u>10 yrs,</u> <u>1 day</u>	
19a. DATE OF OPERATION <u>Feb 22, 1957</u>		19b. MAJOR FINDINGS OF OPERATION <u>Duodenal ulcer penetrating pancreas</u>				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input 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) <u>Robertson</u> (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>Feb 18, 1957</u> , to <u>Feb 24, 1957</u> that I last saw the deceased alive on <u>Feb 24, 1957</u> , and that death occurred at <u>11:30 a. m.</u> , from the causes and on the date stated above.							
23a. SIGNATURE <u>Russell Glider MD</u> (Degree or title)		23b. ADDRESS <u>St Charles, Mo</u>				23c. DATE SIGNED <u>Feb 24, 1957</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		24b. DATE <u>Feb 24 1957</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Sacred Heart Cemetery</u>		24d. LOCATION (City, town, or county) (State) <u>Florissant Mo.</u>	
DATE REC'D BY LOCAL REG. <u>FEB 25 1957</u>		REGISTRAR'S SIGNATURE <u>Marcelle Wilson</u>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Collier Mortuary 10123 St. Charles Rd.</u>			

(Licensed Embalmer's Statement on Reverse Side)

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

APR 20 1961

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 *Sheldon Collier*

Licensed Embalmer No. *3382*

P. O. Address *10123 St. Charles*

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.