

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

59-000861

STATE FILE NUMBER

FILED JAN 19 1959

Registration District No. 115-116

Primary Registration District No. 3020

Registrar's No. 11

300  
1-57

1. PLACE OF DEATH a. COUNTY <b>FRANKLIN</b>			2. USUAL RESIDENCE (Where deceased lived. Institution: Residence before admission) a. STATE <b>Mo</b> b. COUNTY <b>GASCONADE</b>		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>WASHINGTON</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <b>HERMANN 0371</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL <b>ST. FRANCIS HOSPITAL</b> INSTITUTION		Length of stay in 1b <b>5 DAYS</b>	d. STREET ADDRESS (If outside, give location) <b>208 E. 3rd ST</b>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last <b>AUGUST WILLIAM SIGHT</b>			4. DATE OF DEATH Month Day Year <b>JAN 13 - 1959</b>		
5. SEX <b>MALE 0</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>NOV-26-1889</b>		9. AGE (in years last birthday) <b>69</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>PUBLIC OIL DEALER</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>OIL</b>	11. BIRTHPLACE (City and state or country) <b>RTS HERMANN Mo</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>
13a. FATHER'S NAME <b>HENRY SIGHT</b>		13b. MOTHER'S MAIDEN NAME <b>WILHELMINA SCHULTZ</b>		14. NAME OF HUSBAND OR WIFE <b>ELVIRA SIGHT</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>—</b>		17. INFORMANT Address <b>Mrs ELVIRA SIGHT HERMANN Mo</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pulmonary Embolism</b>					INTERVAL BETWEEN ONSET AND DEATH <b>7 days</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <b>arteriosclerotic Heart Disease</b>					<b>10 Years</b>
DUE TO (c) <b>Hypertension</b>					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>Hypertension</b>					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)		
20c. TIME OF INJURY Hour Month, Day, Year a.m. p.m.					
20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE <input type="checkbox"/> WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION COUNTY STATE	
21. I attended the deceased from <b>March 1956</b> , to <b>Jan. 13, 1959</b> and last saw <sup>him</sup> <del>her</del> alive on <b>Jan. 13, 1959</b> Death occurred at <b>1:00 P.M.</b> on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE (Degree or title) <b>Carol T. Shaw MD</b>			22b. ADDRESS <b>Hermann, Missouri</b>		22c. DATE SIGNED <b>1-14-59</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE <b>1/16/59</b>	23c. NAME OF CEMETERY OR CREMATORY <b>HERMANN CEMETERY</b>		23d. LOCATION (City, town, or county) (State) <b>HERMANN Mo</b>
24. FUNERAL DIRECTOR <b>HUGO H. BLUMER</b>		ADDRESS <b>HERMANN Mo</b>		25. DATE RECD. BY LOCAL REG. <b>1/15/59</b>	26. REGISTRAR'S SIGNATURE <b>7 E. Steidmann, G. Steidmann</b>

Doctor, coroner, etc. must use only standard nomenclature in Item 18. No symptoms will be listed. All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

APR 23 1961

MS AUG 3 1961

JAN 27

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 *Stegast Deiner* .....  
Licensed Embalmer No. *3160* .....  
P. O. Address *Herrmann Me* .....

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.