

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-007647

STATE FILE NUMBER

2 1406

REGISTRATION DISTRICT NO. FEB 24 1959 PRIMARY REGISTRATION DISTRICT NO. REGISTRAR'S SIGNATURE

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis		c. CITY OR TOWN St. Louis	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION St. Anthony's Hosp.		d. STREET ADDRESS (If outside, give location) 3450 Eads	
3. NAME OF DECEASED (Type or print) First MAUDE Middle M. Last SITZES		4. DATE OF DEATH Month 2 Day 8 Year 1959	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8-6-1880
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home	11. BIRTHPLACE (City and state or country) Lodge, Missouri
13a. FATHER'S NAME Lawson M. Sitzes		13b. MOTHER'S MAIDEN NAME Jane Goodson	14. NAME OF HUSBAND OR WIFE Lee Sitzes
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. ?	17. INFORMANT Address Lyman Sitzes, 4118 Fairview
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Pulmonary Edema</u> DUE TO (b) <u>Arteriosclerotic Heart Disease</u> DUE TO (c) <u>420.0</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Hypostatic Pneumonia</u>			INTERVAL BETWEEN ONSET AND DEATH <u>24 Hrs.</u> <u>5 yrs.</u>
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 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 <u>1954</u> to <u>2/7/59</u> and last saw ^{her} him alive on <u>2/7/59</u> Death occurred at <u>6:15 A.M.</u> on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <u>Charles Spalding M.D.</u>		22b. ADDRESS <u>7430 Virginia Ave</u>	
		22c. DATE SIGNED <u>2/9/59</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		23b. DATE <u>2-10-1959</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Old Trace Creek</u>		23d. LOCATION (City, town, or county) (State) <u>Glenallen, Missouri</u>	
24. FUNERAL DIRECTOR ADDRESS <u>McLAUGHLIN'S, 2301 Lafayette Ave.</u>		25. DATE RECD. BY LOCAL REG. <u>FEB 9 '59</u>	
		26. REGISTRAR'S SIGNATURE <u>Loard Smith, M.D.</u>	

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

All diseases in Part I must be causally related.

VII 20290
91. 2-180

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 *James P. C. Luper*
Licensed Embalmer No. *755*
P. O. Address *H. Luper*

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.