

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-028119

STATE FILE NUMBER

FILED VS. SEP 1 1959 032

Registration District No. _____ Primary Registration District No. _____ Registrar's No. 57

1. PLACE OF DEATH a. COUNTY <u>Bollinger</u>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo</u> b. COUNTY <u>Bollinger</u>		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Grassy-Fillmore twp</u>		Length of stay in lb <u>90 yrs</u>	c. CITY OR TOWN <u>Grassy</u>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Home</u>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>Grassy R R-1</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>ADAM</u> Middle <u>(None)</u> Last <u>SITZE</u>			4. DATE OF DEATH Month <u>Aug.</u> Day <u>22</u> Year <u>1959</u>		
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>4-24-1869</u>	9. AGE (last birthday) <u>90</u>	IF UNDER 1 YEAR Months _____ Days _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Merchant-Farming</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Gen. Merc. store</u>		11. BIRTHPLACE (City and state or country) <u>Grassy, Mo</u>	12. CITIZEN OF WHAT COUNTRY <u>U.S.</u>
13a. FATHER'S NAME <u>Jacob Sitze</u>		13b. MOTHER'S MAIDEN NAME <u>Sarah Lutes</u>		14. NAME OF HUSBAND OR WIFE <u>Frances Burk Sitze</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>No</u>		17. INFORMANT <u>Denver Sitze Grassy, Mo</u> Address _____	
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 circulatory Collapse</u>					INTERVAL BETWEEN ONSET AND DEATH <u>acute</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.					
DUE TO (b) <u>Pyelophlebotrombosis</u>					<u>3 years</u>
DUE TO (c) <u>Chronic Portal cirrhosis</u>					<u>4 years</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Arteriosclerosis</u>				PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
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.) <u>none</u>			
20c. TIME OF INJURY Hour _____ a.m. _____ p.m. Month, Day, Year _____					
20d. INJURY OCCURRED WHILE AT WORK <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>May 30, 1957</u> to <u>Aug. 21, 1959</u> and last saw him <u>live</u> on <u>Aug. 21, 1959</u> Death occurred at <u>6:30 a.m.</u> m the date stated above, and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE (Degree or title) <u>William J. Freitas, D.O.</u>			22b. ADDRESS <u>Lutesville Mo.</u>		22c. DATE SIGNED <u>8-26-59</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>	23b. DATE <u>8-24-59</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Bollinger Co. Mem. Cem.</u>		23d. LOCATION (City, town, or county) (State) <u>Lutesville, Mo</u>	
24. FUNERAL DIRECTOR <u>Gene Ward Lutesville, Mo</u> ADDRESS _____			25. DATE RECD. BY LOCAL REG. <u>8/28/59</u>		26. REGISTRAR'S SIGNATURE <u>Mrs. Buford Crader</u>

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by
or by Herbert Liley, Student Embalmer No. 579
working under my personal supervision.

Student Herbert Liley
Signature of Student Embalmer

Signed R. O. Raint

Licensed Embalmer No. 4538

P. O. Address Jackson, M

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to conform 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.