

FEDERAL DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS SEP 26 1960

221-60-037153

Registration District No. 333 Primary Registration District No. 3074 Registrar's No. _____ STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY <u>Scott</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>Scott</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Sikeston</u>		Length of stay in 1b <u>41 YRS</u>	c. CITY OR TOWN <u>Sikeston</u> Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
c. FULL NAME OF HOSPITAL OR INSTITUTION <u>903 HAWTHORNE</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>903 HAWTHORNE</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <u>ROBERT</u> Middle <u>JOSEPH</u> Last <u>SITZES</u>			4. DATE OF DEATH Month <u>9</u> Day <u>5</u> Year <u>1960</u>		
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>3-19-1919</u>	9. AGE (last birthday) <u>41</u>	IF UNDER 1 YEAR Months <u>5</u> Days <u>16</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FARMER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>-</u>	11. BIRTHPLACE (City and state or country) <u>Sikeston Mo</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>
13a. FATHER'S NAME <u>JACOB SITZES</u>		13b. MOTHER'S MAIDEN NAME <u>ANNA WHITNER</u>		14. NAME OF HUSBAND OR WIFE <u>RACHEL E.</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>492-42-1453</u>	17. INFORMANT Address <u>Mrs Rachel E Sitzes Sikeston Mo</u>
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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>Pneumatic heart disease</u>		INTERVAL BETWEEN ONSET AND DEATH <u>?</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) _____ DUE TO (c) _____	

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)		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	
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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 _____ a.m. _____ p.m. Month, Day, Year _____	20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" 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 Nov 1, 1950 to Sept 5, 1960 and last saw her/him alive on Aug 12, 1960
Death occurred at 8:25 P.M. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) <u>Wm. C. Critchlaw MD</u>	22b. ADDRESS <u>Sikeston, Mo</u>	22c. DATE SIGNED <u>Sept 10, 1960</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>9-7-1960</u>	23c. NAME OF CEMETERY OR CREMATORY <u>GARDEN OF MEMORIES Sikeston</u>	23d. LOCATION (City, town, or county) (State) <u>Mo.</u>
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24. FUNERAL DIRECTOR ADDRESS <u>Welch Funeral Home Sikeston Mo</u>	25. DATE RECD. BY LOCAL REG. <u>9-12-60</u>	26. REGISTRAR'S SIGNATURE <u>Mrs Ella Hunter</u>
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DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

VS SEP 26 1960

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

Student _____
Signature of Student Embalmer

Signed Raymond Crews

Licensed Embalmer No. 3467

P. O. Address Sikeston

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.