

AMENDED

Registration District No. 119 Primary Registration District No. 5443 Registrar's No. 48

STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY <b>Gasconade</b>		2. USUAL RESIDENCE (Where deceased lived. If 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>Roark Twp</b>	Length of stay in 1b <b>2 1/2 Yrs</b>	c. CITY OR TOWN <b>(Raark Twp)</b>	Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> #
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Greene Valley Nursing Home</b>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> #	d. STREET ADDRESS (If outside, give location) <b>3 1/2 Mi. S. W. of Hermann</b>
Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> #			

3. NAME OF DECEASED (Type or print) First <b>OTTO</b> Middle <b>SICHT</b> Last <b>SICHT</b>			4. DATE OF DEATH Month <b>Sept</b> Day <b>26</b> Year <b>1961</b>	
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5. SEX <b>Male</b>	6. COLOR OR RACE <b>Cau.</b>	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> # Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>3/26/1886</b>	9. AGE (last birthday) <b>75</b>	IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/>	IF UNDER 24 HR Hours <input type="checkbox"/> Min. <input type="checkbox"/>
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Carpenter</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>Building</b>	11. BIRTHPLACE (City and state or country) <b>Hermann, Mo</b>	12. CITIZEN OF WHAT COUNTRY <b>US</b>
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13a. FATHER'S NAME <b>Henry Sicht</b>	13b. MOTHER'S MAIDEN NAME <b>Unkown</b>	14. NAME OF HUSBAND OR WIFE <b>-----</b>
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>	17. INFORMANT <b>Mrs. J. S. Sicht Hermann, Mo</b>	Address <b>Hermann, Mo</b>
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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) <b>CEREBRAL THROMBOSIS</b>		INTERVAL BETWEEN ONSET AND DEATH <b>1 day</b>
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) <b>CARCINOMA OF COLON</b>	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.)
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20c. TIME OF INJURY Hour _____ a.m. _____ p.m.	Month, Day, Year _____
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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 <b>Hermann</b>	COUNTY <b>Mo</b>	STATE <b>Mo</b>
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21. I attended the deceased from 1958 to 9-26-61 and last saw her/him alive on 9-26-61  
Death occurred at H A m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) <b>George M. Workman M.D.</b>	22b. ADDRESS <b>Hermann, Mo</b>	22c. DATE SIGNED <b>9-27-61</b>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>9/28/1961</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Hermann Cemetery</b>	23d. LOCATION (City, town, or county) <b>Hermann Mo</b>	(State)
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24. FUNERAL DIRECTOR <b>HERMAN BLUMER INC</b>	ADDRESS <b>Hermann, Mo</b>	25. DATE RECD. BY LOCAL REG. <b>9-27-61</b>	26. REGISTRAR'S SIGNATURE <b>Delma Uffelma</b>
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AMENDMENTS ON THIS RECORD ARE AS FOLLOWS  
 DATE AMENDED  
 INSTEAD OF  
 DOCUMENT  
 MEDICAL CERTIFICATION  
 BY AFFIDAVIT OF  
 ITEM NO. SHOULD READ

**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 ORVAL GRONER Student Embalmer No. 644

working under my personal supervision.

Student Orval Groner  
Signature of Student Embalmer

Signed Hughes + Blume  
Licensed Embalmer No. 3160

P. O. Address Herrmann M

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.