

**MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH**

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✓ 41985
165

1. PLACE OF DEATH

County St. Francois
Township St. Francois
City Farmington, Mo.

Registration District No. 773
Primary Registration District No. 6.018A

File No. _____
Registered No. _____ Ward _____

2. FULL NAME Pearl Sitze

(a) Residence, No. Bessville, Mo. St. _____ Ward _____
(Usual place of abode) (If nonresident, give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Single

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF _____

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) 1896

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.
35 ? ?

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. None

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc. _____

10. Date deceased last worked at this occupation (month and year) _____ 11. Total time (years) spent in this occupation _____

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Bessville, Mo.

13. NAME Joe Abe Sitze

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Bessville Mo.

15. MAIDEN NAME Mary Eliz Lawson

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Unknown

17. INFORMANT (ADDRESS) Hospital Records Farmington, Mo.

18. BURIAL, CREMATION, OR REMOVAL PLACE Hospital Cemetery DATE 12-19 1931

19. UNDERTAKER (ADDRESS) Hospital No. 4 Farmington

20. FILED Dec 22, 1931 B. J. Robinson Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 12-18, 1931

22. I HEREBY CERTIFY, That I attended deceased from 7-14, 1931, to 12-18, 1931

I last saw him alive on 12-17, 1931. Death is said to have occurred on the date stated above, at 5:30 a.m.

The principal cause of death and related causes of importance were as follows:

Acute recurrent nephritis
130

Date of onset _____

Other contributory causes of importance: _____

Name of operation _____ Date of _____
What test confirmed diagnosis? _____ Was there an autopsy? _____

23. If death was due to external causes (violence), fill in also the following: Accident, suicide, or homicide? _____ Date of injury _____, 19 _____

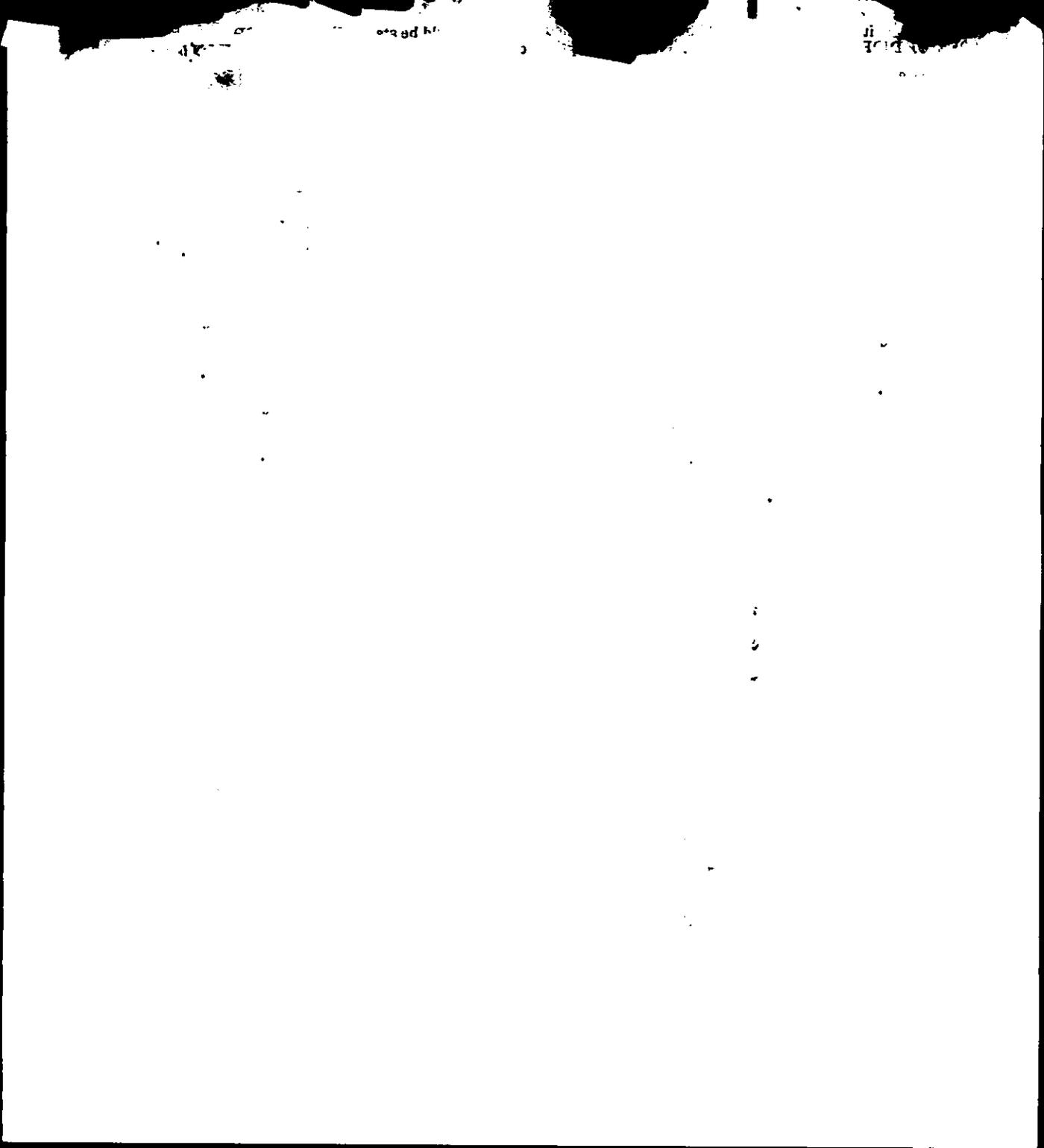
Where did injury occur? _____ (Specify city or town, county, and State)
Specify whether injury occurred in industry, in home, or in public place. _____

Manner of injury _____
Nature of injury _____

24. Was disease or injury in any way related to occupation of deceased? _____
If so, specify _____

(Signed) Fred Long, M. D.
(Address) Farmington

CAUSE OF DEATH in plain terms, so that it can be understood by the layman. Item of information should be stated EXACTLY. PHYSICIAN's name and address. Exact statement of OCCUPATION is very important.



**MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH**

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

1. PLACE OF DEATH

County St. Francois
Township 11
City 11 (No. 11)

Registration District No. 773
Primary Registration District No. 6018a

File No. _____
Registered No. 165- Ward) _____

2. FULL NAME

Bevel Sitze

(a) Residence, No. _____ St., _____ Ward.

(Usual place of abode)

(If nonresident, give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX <u>F</u>	4. COLOR OR RACE <u>W</u>	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) <u>W</u>		
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF				
6. DATE OF BIRTH (MONTH, DAY, AND YEAR)				
7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, _____ hrs. or _____ min.
OCCUPATION	8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc.			
	9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.			
	10. Date deceased last worked at this occupation (month and year)		11. Total time (years) spent in this occupation	
12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)				
FATHER	13. NAME			
	14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)			
MOTHER	15. MAIDEN NAME			
	16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)			
17. INFORMANT (ADDRESS)				
18. BURIAL, CREMATION, OR REMOVAL PLACE DATE				
19. UNDERTAKER (ADDRESS)				
20. FILED <u>Feb 5 1932</u> <u>F. J. Robinson</u> Registrar.				

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 12/18 1931

22. I HEREBY CERTIFY, That I attended deceased from _____ to _____, 19____.

I last saw h. _____ alive on _____, 19____. Death is said to have occurred on the date stated above, at _____ m.

The principal cause of death and related causes of importance were as follows:

acute recurrent nephritis - cause unknown

Date of onset

Other contributory causes of importance:

130

Name of operation _____ Date of _____

What test confirmed diagnosis autopsy Was there an autopsy? yes

23. If death was due to external causes (violence), fill in also the following: Accident, suicide, or homicide? _____ Date of injury _____, 19____.

Where did injury occur? _____ (Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place.

Manner of injury _____

Nature of injury _____

24. Was disease or injury in any way related to occupation of deceased? _____

If so, specify _____

(Signed) Fred Long, M. D.

(Address) F. Longington

SUPPLEMENTARY

WRITE PLEASE WITH UNFADING INK --- Every item of information should be stated EXACTLY. PHYSICIAN'S statement of OCCUPATION is very important. DEATH in plain terms, so that may be properly classified. Exact statement of OCCUPATION is very important.

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW

WRITE PLEASE WITH UNFADING INK --- RECORD

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