

FILED MAR 9 1945

Registration District No. 53

Primary Registration District No. 3010

Registrar's No. 37.

1. PLACE OF DEATH:

(a) County Cape Girardeau  
(b) City or town Cape Girardeau  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
Southeast Missouri  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 4 days (Specify whether  
In this community 4 days years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Bollinger  
(c) City or town Rural (If outside city or town limits, write "RURAL")  
(d) Street No. \_\_\_\_\_ (If rural, give location)  
(e) Citizen of foreign country? NO (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME Sarah Caroline Sitze

3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced married  
6. (b) Name of husband or wife Jacob Napoleon Sitze 6. (c) Age of husband or wife if alive 48 years  
7. Birth date of deceased July 2 1883 (Month) (Day) (Year)

8. AGE: Years 61 Months 6 Days 28 If less than one day hr. \_\_\_\_\_ min. \_\_\_\_\_

9. Birthplace Bollinger County Mo (City, town, or county) (State or foreign country)

10. Usual occupation house wife

11. Industry or business \_\_\_\_\_

12. Name P. H. Pulliam

13. Birthplace Bollinger Co. Mo (City, town, or county) (State or foreign country)

14. Maiden name Sarah C. Green

15. Birthplace Bollinger Co. Mo (City, town, or county) (State or foreign country)

16. (a) Informant Charles E. Sitze

(b) Address Bessville Mo

17. (a) Rural (b) Date thereof 7/1/45 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Huffman Fork Cemetery

18. (a) Signature of funeral director Robert G. Green

(b) Address 2645 S. 2nd St. St. Louis

19. (a) 2645 (b) H. W. Phelps (Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan day 30 year 1945 hour 5 minute 30 P. M.

21. I hereby certify that I attended the deceased from 1/25 1945 to 1/30 1945 that I last saw him alive on 1/30 1945 and that death occurred on the date and hour stated above.

Immediate cause of death myocardial infarction

Due to \_\_\_\_\_  
Due to \_\_\_\_\_

Other conditions (Include pregnancy within 3 months of death) Cholelithiasis

Major findings: Large gall bladder highly inflamed  
Of operations \_\_\_\_\_  
Of autopsy \_\_\_\_\_

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) \_\_\_\_\_  
(b) Date of occurrence \_\_\_\_\_  
(c) Where did injury occur? \_\_\_\_\_ (City or town) (County) (State)  
(d) Did injury occur in or about home, on farm, in industrial place, in public place? \_\_\_\_\_

While at work? \_\_\_\_\_ (Specify type of place) (c) Means of injury \_\_\_\_\_

23. Signature C. H. Phelps (M. D. or other) \_\_\_\_\_  
Address Call Center Date signed 7/1/45

101 X

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

16  
1  
4

RECEIVED

District Health Officer No. 4  
District File Number 345-308  
Date Filed 3-6-45

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.....  
....., Registered Apprentice No.....  
working under my personal supervision.

Signed Glen Wilson

Licensed Embalmer No. 2828

P. O. Address Jackson Mo

**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 this body is not embalmed, fact should be so stated above.**