

FILED MAR 24 1947
Registration District No. **22**

Primary Registration District No. **1000**

1. PLACE OF DEATH:

(a) County Buchanan

(b) City or town St. Joseph
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: Missouri Methodist Hospital
(If not in hospital or institution, write street number, or location)

(d) Length of stay: In hospital or institution 3 days
(Specify whether years, months or days)

In this community 3 days

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Buchanan

(c) City or town St. Joseph
(If outside city or town limits, write "RURAL")

(d) Street No. 2834 South 19th Street
(If rural, give location)

(e) Citizen of foreign country? No (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME Oscar David Bittick

3. (b) If veteran, name war No 3. (c) Social Security No. None

4. Sex Male 5. Color or race White

6. (a) Single, widowed, married, divorced single

6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased March third 1947
(Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
<u>0</u>	<u>0</u>	<u>3</u>	--- hr. --- min.

9. Birthplace St. Joseph, Missouri.
(City, town, or county) (State or foreign country)

10. Usual occupation none

11. Industry or business none

12. Name William W. Bittick

13. Birthplace St. Joseph, Missouri.
(City, town, or county) (State or foreign country)

14. Maiden name Mary A. Deputy

15. Birthplace Council Bluff, Iowa.
(City, town, or county) (State or foreign country)

16. (a) Informant William W. Bittick

(b) Address 2834 South 19th. Street

17. (a) 2834 South 19th. Street (b) Date thereof 3/8/47
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Mt. Auburn Cemetery

18. (a) Signature of funeral director Wm. R. Sidenfahn

(b) Address 602 South 10th Street

19. (a) 3-13-47 (b) L. L. Jenkins
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 6th.
year 1947 hour 2 minute 55 P. M.

21. I hereby certify that I attended the deceased from March 3 19 47 to March 7 19 47
that I last saw him alive on March 6 19 47
and that death occurred on the date and hour stated above.

Immediate cause of death Congenital Heart Disease

Duration 3 days

Due to _____

Due to _____

Other conditions 15.7E
(Include pregnancy within 3 months of death)

Major findings: 15.7E

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)

(e) Means of injury 0

23. Signature Oscar W. Stary MD (M. D. or other) _____

Address 405 North 10th Date signed 3-8-47

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

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 *Did not Embalm*
Mollie E. Sidenfaden Fox

Licensed Embalmer No. *4235*

P. O. Address *St. Joseph, 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.