

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **10592**  
Registrar's No. **2035**

FILED MAR 24 1952

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003**

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <b>Tennessee</b> b. COUNTY <b>Obion</b>	
b. CITY OR TOWN <b>St. Louis</b>		c. CITY OR TOWN <b>Union City</b> <b>8410</b>	
c. LENGTH OF STAY (In this place)		d. STREET ADDRESS (If rural, give location) <b>8</b>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>Missouri Pacific Hospital</b>			

3. NAME OF DECEASED (Type or Print) <b>ELIJAH SITTON</b>			4. DATE OF DEATH (Month) (Day) (Year) <b>March 1, 1952</b>		
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>Widowed</b>	8. DATE OF BIRTH <b>April 3, 1858</b>		9. AGE (In years last birthday) <b>93</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Carpenter Foreman</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Mo. Pac. R.R.</b>	11. BIRTHPLACE (State or foreign country) <b>Jonesboro, Ill.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>

13a. FATHER'S NAME <b>Isaac Sitton</b>		13b. MOTHER'S MAIDEN NAME <b>Jane Alsop</b>		14. NAME OF HUSBAND OR WIFE <b>Mary</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT'S SIGNATURE OR NAME <b>Millard Sitton, Dupu, Ill.</b>	

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)		MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH
1. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Cardiac factors</b>		DUE TO (b) <b>Cerebral thrombus Rt</b>			<b>1 day</b>
*This does not mean the mode of dying, such as heart failure, asphyxia, etc. It means the disease, injury, or complication which caused death.		DUE TO (c) <b>Generalized arteriosclerosis</b>			<b>8 days</b>
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <b>Hypertrophic prostate</b>					<b>20 years</b>
19a. DATE OF OPERATION <b>X</b>		19b. MAJOR FINDINGS OF OPERATION <b>X</b>			20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>

21a. ACCIDENT SUICIDE HOMICIDE (Specify) <b>X</b>		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>X</b>		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) <b>X</b>		21e. INJURY OCCURRED WHILE AT WORK <input checked="" type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? <b>332X</b>	

22. I hereby certify that I attended the deceased from **Feb 25, 1952** to **Feb 25, 1952** that I last saw the deceased alive on **March 1, 1952**, and that death occurred at **6:30 p.m.**, from the causes and on the date stated above.

23a. SIGNATURE <b>W. W. Kelley M.D.</b> (Degree or title)		23b. ADDRESS <b>Mo. Pac. Hosp.</b>		23c. DATE SIGNED <b>March 1, 52</b>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>		24b. DATE <b>3-1-52</b>		24c. NAME OF CEMETERY OR CREMATORY <b>Thebes, Ill.</b>	

DATE REC'D BY LOCAL REG. <b>MAR 3 1952</b>		REGISTRAR'S SIGNATURE <b>Carl Smith M.D.</b>		25. FUNERAL DIRECTOR'S SIGNATURE <b>Albert H. Hoppe</b> ADDRESS <b>4700 Washington Blvd.</b>	
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

1957  
AUG 7 1957

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 Mc

working under my personal supervision.

Student Embalmer No. ....

Signed Etton R. Remelius

Signed .....  
Student Embalmer

Licensed Embalmer No. 42 83

P. O. Address St. Louis, 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.