

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

9257

STATE FILE NUMBER

FILED APR 8 - 1957

Registration District No. 175 Primary Registration District No. 3076 Registrar's No. 41

Health,
Welfare
Public
Service

300
1-56

The medical certification in the specimen form must be completed in the same manner as the standard form. Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related. Coroner cannot certify to a death due to natural causes.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

| | | | | | | | |
|--|-------------------------------|--|--|--|--|---|--|
| 1. PLACE OF DEATH a. COUNTY Lawrence | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Minnesota b. COUNTY McLeod | | | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Aurora | | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | c. CITY OR TOWN Hutchinson | | 8220 8 Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Aurora Hospital | | | Length of stay in lb 1 week | d. STREET ADDRESS (If outside, give location) 817 Ivy Lane | | | Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> |
| 3. NAME OF DECEASED (Type or print) First EDWARD Middle FREDRICK Last SITZ | | | | 4. DATE OF DEATH Month April Day 1 Year 1957 | | | |
| 5. SEX Male | 6. COLOR OR RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH Jan. 13, 1875 | | 9. AGE (In years last birthday) 82 IF UNDER 1 YEAR: Months _____ Days _____ IF UNDER 24 HRS.: Hours _____ Min. _____ | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer | | | 10b. KIND OF BUSINESS OR INDUSTRY Farming | | 11. BIRTHPLACE (City and state or country) Hutchinson, Minn. | | 12. CITIZEN OF WHAT COUNTRY? U. S. A. |
| 13. FATHER'S NAME Edward Sitz | | | | 14. MOTHER'S MAIDEN NAME Augusta Heller | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No | | | 16. SOCIAL SECURITY NO. None | | 17. INFORMANT Mrs. Don Froemming, Billings, Mo. | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Nephritis | | | | | | | INTERVAL BETWEEN ONSET AND DEATH 10 days |
| 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) | | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> 2 |
| 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.) | | | | |
| 20c. TIME OF INJURY Hour _____ Month _____ Day _____ a. m. _____ p. m. _____ | | | | | | | |
| 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 | | COUNTY _____ STATE _____ | |
| 21. I attended the deceased from January 1957 to March 1957 and last saw ^{her} him alive on 25 March 57 Death occurred at 9 P. m. on the date stated above; and to the best of my knowledge, from the causes stated. | | | | | | | |
| 22a. SIGNATURE (Degree or title) Karl F. Leidinger, Jr. M.D. | | | | 22b. ADDRESS Billings, Mo. | | 22c. DATE SIGNED 3 Apr. 57 | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Removal | | 23b. DATE 4/3/1957 | 23c. NAME OF CEMETERY OR CREMATORY Quast Funeral Home | | 23d. LOCATION (City, town, or county) Hutchinson, Minnesota | | (State) |
| 24. FUNERAL DIRECTOR Glean Harris | | | ADDRESS Clever, Mo. | | 25. DATE RECD. BY LOCAL REG. 4-3-57 | | 25. REGISTRAR'S SIGNATURE Ora McNatt |

(Licensed Embalmer's Statement on Reverse Side)

157

SEP 19 1962

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 Student Embalmer No. working under my personal supervision..

Student.....

Signature of Student Embalmer

Signed.....
Julean Harris

Licensed Embalmer No. 4390

P. O. Address.....
Clover, 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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.