

FILED VS AUG 14 1959

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-025833
STATE FILE NUMBER

Registration District No. 181 Primary Registration District No. 4293 Registrar's No. 24

5. 300
1-57

1. PLACE OF DEATH a. COUNTY <u>LINCOLN</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MISSOURI</u> b. COUNTY <u>LINCOLN</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>ELS BERRY</u>	Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>WINFIELD</u>	Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>LADELLE N.H.</u>	Length of stay in lb <u>5 WKS.</u>	<u>057</u> ^d STREET ADDRESS <u>0</u>	(If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First Middle Last <u>MARGARET COLEMAN SITTON</u>			4. DATE OF DEATH Month Day Year <u>JUNE 27, 1959</u>		
5. SEX <u>Female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>NOV. 8, 1880</u>	9. AGE (In years last birthday) <u>78</u>	IF UNDER 1 YEAR Months Days Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>OWN HOME</u>	11. BIRTHPLACE (City and state or country) <u>EOLIA, Mo.</u>	12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
---	--	---	--

13a. FATHER'S NAME <u>JOHN HUCKSTEP</u>	13b. MOTHER'S MAIDEN NAME <u>MILDRED ALLEN</u>	14. NAME OF HUSBAND OR WIFE <u>SIMPSON SITTON</u>
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO</u>	16. SOCIAL SECURITY NO. <u>NONE</u>	17. INFORMANT <u>OPAL DIXON</u> Address <u>WINFIELD, Mo.</u>

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Myocarditis</u>		INTERVAL BETWEEN ONSET AND DEATH <u>6 weeks</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <u>Acute Viral Influenza</u>	<u>6 weeks</u>
	DUE TO (c) <u>481X</u>	
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"/>

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 a.m. Month, Day, Year p.m.		
20d. INJURY OCCURRED WHILE AT <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 Aug. 7, 1959 to June 27, 1959 and last saw her alive on June 27, 1959
Death occurred at 2:50 (PST) A.M. on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) <u>Frank L. Sutton, D.O.</u>	22b. ADDRESS <u>Winfield, Mo.</u>	22c. DATE SIGNED <u>June 29, 1959</u>
--	--------------------------------------	--

23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE <u>6-28-59</u>	23c. NAME OF CEMETERY OR CREMATORY <u>NEW SALEM</u>	23d. LOCATION (City, town, or county) (State) <u>WINFIELD, Mo.</u>
--	-----------------------------	--	---

24. FUNERAL DIRECTOR <u>O. C. Ricks</u>	ADDRESS <u>Elsberry, Mo.</u>	25. DATE RECD. BY LOCAL REG. <u>6/30/59</u>	26. REGISTRAR'S SIGNATURE <u>Mrs. Clarence Kientzy</u>
--	---------------------------------	--	---

(Licensed Embalmer's Statement on Reverse Side)

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.

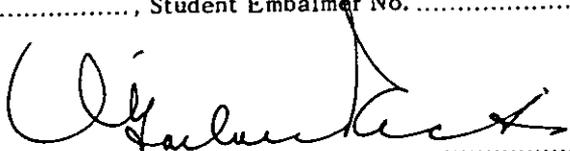
USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

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 

Licensed Embalmer No. 4012

P. O. Address Edsberry, 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.