

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

63-022239

Registration District No. _____

318

Primary Registration District No. _____

1003

Registrar's No. _____

5157

STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

- AMENDED

VS 300
Rev. 4/59

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS INSTEAD OF

ITEM NO. SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

FILED MAY 17 1963

1. PLACE OF DEATH a. COUNTY		b. CITY (if outside corporate limits, give TOWNSHIP only) OR TOWN		Length of stay in 1b DOA		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE		b. COUNTY												
		St. Louis				Missouri														
c. FULL NAME OF (if NOT in hospital, give location) HOSPITAL OR INSTITUTION		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location)		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>														
		St. Louis City Hospital				927 Maple Pl.														
3. NAME OF DECEASED (Type or print)			First			Middle			Last			4. DATE OF DEATH Month			Day			Year		
			LeRoy			A.			Sittig			May			10			1963		
5. SEX		6. COLOR OR RACE		7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH		9. AGE (last birthday)		IF UNDER 1 YEAR Months		IF UNDER 24 HR Days		Hours		Min.				
Male		White				1025 1890		72												
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (City and state or country)				12. CITIZEN OF WHAT COUNTRY								
Shoe Cutter				Shoe Mfr.				St. Louis Mo.				U.S.A.								
13a. FATHER'S NAME				13b. MOTHER'S MAIDEN NAME				14. NAME OF HUSBAND OR WIFE												
William R. Sittig				Mary Smith				Frances Schlautmann												
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.				17. INFORMANT Address				Sittig								
No								Frances Sittig				Above								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>S. R. 4 1/2 7 T HR 3 4 B 0 3 1 0</i>																				
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____ <i>4201</i>																				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)												PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown								
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. p.m.		Month, Day, Year																		
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 <i>Jan 1, 1955</i> to <i>May 10, 1963</i> and last saw him alive on <i>MAY 4, 1963</i> Death occurred at <i>5:35 P.</i> m on the date stated above; and to the best of my knowledge, from the causes stated.																				
22a. SIGNATURE <i>Dwelle Osborn M.D.</i>								22b. ADDRESS 2100 Hudson Br. St. Louis 36 Mo.				22c. DATE SIGNED 5-13-63								
23b. BURIAL, CREMATION, REMOVAL (Specify) <i>REMOVAL</i>				23b. DATE 5-14-63		23c. NAME OF CEMETERY OR CREMATORY Valhalla Cemetery				23d. LOCATION (City, town, or county) (State) St. Louis Co. Mo.										
24. FUNERAL DIRECTOR Jay B. Smith Maplewood MO.						25. DATE RECD. BY LOCAL REG. MAY 13 1963		26. REGISTRAR'S SIGNATURE <i>Paul Smith M.D.</i>												

USE BLACK INK OR TYPEWRITER RIBBON

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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 Melvin Barteen

Licensed Embalmer No. 4903

P. O. Address St. Louis

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.