

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

63-040548
STATE FILE NUMBER

Registration District No. 179 Primary Registration District No. 5668 Registrar's No. 151

DO NOT WRITE ON THIS STUB
AMENDED

VS 300
Rev. 4/59

10570
20570
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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

DOCUMENT

MEDICAL CERTIFICATION

ITEM NO. SHOULD READ

BY AFFIDAVIT OF

| | | | |
|--|---|---|--|
| 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) <u>Clark</u> | | Length of stay in lb <u>3 Mo.</u> | c. CITY OR TOWN <u>Moscow Mills</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>Jells Nursing Home</u> | | Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> | d. STREET ADDRESS (If outside, give location) <u>Jells Nursing Home</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> |
| 3. NAME OF DECEASED (Type or print) First <u>HUGH</u> Middle <u>MILLER</u> Last <u>SITTON</u> | | | 4. DATE OF DEATH Month <u>Oct.</u> Day <u>18</u> Year <u>1963</u> |
| 5. SEX <u>Male</u> | 6. COLOR OR RACE <u>White</u> | 7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input checked="" type="checkbox"/> | 8. DATE OF BIRTH <u>Aug 29 1889</u> |
| 9. AGE (last birthday) <u>74</u> | | IF UNDER 1 YEAR Months <u>1</u> Days <u>19</u> | IF UNDER 24 HR Hours <u></u> Min. <u></u> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Farming</u> | 11. BIRTHPLACE (City and state or country) <u>Winfield Mo.</u> |
| 12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u> | | 13. FATHER'S NAME <u>Lewis Sitton</u> | |
| 13b. MOTHER'S MAIDEN NAME <u>Flora Broyles</u> | | 14. NAME OF HUSBAND OR WIFE | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of serv.) <u>None</u> | | 16. SOCIAL SECURITY NO. <u></u> | |
| 17. INFORMANT <u>Sam Sitton</u> | | Address <u>146 Deekcamp Lane St Charles Mo.</u> | |
| 18. CAUSE OF DEATH (Enter only one cause per line) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Congestive Heart Failure</u> DUE TO (b) <u>Arterio Sclerosis</u> DUE TO (c) <u></u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. | | | INTERVAL BETWEEN ONSET AND DEATH <u>2 yrs</u> <u>5 yrs.</u> |
| 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 <u></u> a.m. <u></u> p.m. <u></u> | Month, Day, Year <u></u> | | |
| 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 <u>June 3 1959</u> to <u>Oct. 18 1963</u> and last saw him alive on <u>Oct. 18 1963</u> Death occurred at _____ m on the date stated above, and to the best of my knowledge, from the causes stated. | | | |
| 22a. SIGNATURE <u>H. I. Kelley</u> (Degree or title) <u>DO</u> | | 22b. ADDRESS <u>Troy Mo.</u> | |
| 22c. DATE SIGNED <u>10-21-63</u> | | (State) | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | 23b. DATE <u>Oct. 21 1963</u> | 23c. NAME OF CEMETERY OR CREMATORY <u>New Galilee Cem.</u> | 23d. LOCATION (City, town, or county) <u>Lincoln County Mo.</u> |
| 24. FUNERAL DIRECTOR <u>Wayne McCoy</u> | ADDRESS <u>Troy Mo.</u> | 25. DATE RECD. BY LOCAL REG. <u>10-22-63</u> | 26. REGISTRAR'S SIGNATURE <u>Charlotte Leek</u> |

USE BLACK INK OR TYPEWRITER RIBBON

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 *D. W. McLaughlin*

Licensed Embalmer No. *3087*

P. O. Address *Troy, 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.