

REC'D NOV 10 1938

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

36359
Do not use this space.

1. PLACE OF DEATH

(a) County New Madrid Registration District No. 605
(b) Township Como Primary Registration District No. 4359 Registered No. _____
(c) City _____ (d) Street No. _____
(If death occurred in Hospital or Institution, write its name instead of street and number) St. _____
(e) Length of residence in city or town where death occurred, yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME

Otis Pitts
(a) Residence, No. _____ St. (If nonresident, give city or town and State)
(Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M. 4. COLOR OR RACE Black 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) ✓

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF ✓

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Oct 21, 1937

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
11 78

OCCUPATION
8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. ✓
9. Industry or business in which work was done, as saw mill, bank, etc. ✓
10. Date deceased last worked at this occupation (month and year) _____ 11. Total time (years) spent in this occupation ✓

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Tripelo Ark.

FATHER
13. NAME Sol Pitts

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Ark

MOTHER
15. MAIDEN NAME Lorene Edwards

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Ark

17. INFORMANT (ADDRESS) John Billops

18. BURIAL, CREMATION, OR REMOVAL PLACE Sweet Home DATE 10-19-38

19. FUNERAL DIRECTOR (NAME) (ADDRESS) None 534

20. FILED 10-19-38 D. Stewart Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Oct. 18 1938

22. I HEREBY CERTIFY, That I attended deceased from No Physician, 19____
I last saw him alive on, 19____. Death is said to have occurred on the date stated above, at 4 P.M.
The principal cause of death and related causes of importance were as follows:

Malaria 3/4 Date of onset _____
Other contributory causes of importance: high fever - convulsions

Name of operation _____ Date of _____
What test confirmed diagnosis? history Was there an autopsy? No

23. If death was due to external causes (violence), fill in also the following: Accident, suicide, or homicide? _____ Date of injury _____, 19____
Where did injury occur? _____ (Specify city or town, county, and State)
Specify whether injury occurred in industry, in home, or in public place.

Manner of injury _____
Nature of injury _____

24. Was disease or injury in any way related to occupation of deceased? _____
If so, specify _____
(Signed) D. Stewart, M. D.
(Address) Parma, Mo.

Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

ATTENTION TO BE PAID TO THE FOLLOWING INFORMATION
ON CERTIFICATES ISSUED BY THE BOARD
OF HEALTH OFFICERS

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

Registered Apprentice No. _____, working under my personal supervision.

Signed _____

Licensed Embalmer No. _____

P. O. Address _____

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, above space should be left blank.