REC'D MAR 15 1939

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

6976
Do not use this space.

1. PLACE OF DEATH
(a) County LACLEDE — Registration District No. 453
(b) Township GASCONADE — Primary Registration District No. 5619 — Registered No.
or
(c) City — (d) Street No. — St.
(If death occurred in Hospital or Institution, write its name instead of street and number)
(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 DAVID LAFATE PITTS
(a) Residence, No. — St.
(Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M
4. COLOR OR RACE: W
5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word): WIDOWER
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF: HANNA RUBLES
6. DATE OF BIRTH (MONTH, DAY, AND YEAR): Not Known
7. AGE: YEARS 70 | MONTHS | DAYS | If LESS than 1 day, ...hrs. or ....min.

OCCUPATION
8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc.: FARMER
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): WRIGHT CO MO.

FATHER
13. NAME
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY): Not Known

MOTHER
15. MAIDEN NAME
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

17. INFORMANT (ADDRESS): Howard Lillard Brownfield Mo.
18. BURIAL, CREMATION, OR REMOVAL
PLACE Cross Roads Cem. DATE Mar 11 1939
19. FUNERAL DIRECTOR (NAME) (ADDRESS): Palmer's Lebanon Mo.
20. FILED ....., 19.....
Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR): Mar 9, 1939
22. I HEREBY CERTIFY, That I attended deceased from 4-3-, 1938, to 7-9-, 1938
I last saw him alive on 7-9-, 1938 Death is said to have occurred on the date stated above, at 11:05 P.m.
The principal cause of death and related causes of importance were as follows:

	Date of onset
Cerebral Hemorrhage	
8 2 W 1	

Other contributory causes of importance:
Varicocele
Bronchial asthma

Name of operation ..... Date of .....
What test confirmed diagnosis? ..... 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? no
If so, specify .....
(Signed) Roland E. Gaston, M.D.
(Address) Nebo, Mo.

(Licensed Embalmer's Statement on Reverse Side)

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should sta
CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very importan
1 X16603

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was not embalmed by ~~me, or by~~ any Body

....., Registered Apprentice No.....

working under my personal supervision.

Signed R. A. Palmer

Licensed Embalmer No. 1161

P. O. Address Lebanon Mo

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comp with the above constitutes grounds for revocation of license.)

If this body is not embalmed, above space should be left blank.

FILL IN ANSWERS TO ALL SPACES CHECKED IN RED PENCIL.

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

6976
Do not use this space.

1. PLACE OF DEATH
(a) County Laclede — Registration District No. 453
(b) Township Gasconade — Primary Registration District No. 5619 — Registered No. 4
(c) City ..... (d) Street No. ..... St.
(If death occurred in Hospital or Institution, write its name instead of street and number)
(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 David Lafate Pitts
(a) Residence, No. ..... St. ☐ .....
(Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M
4. COLOR OR RACE: W
5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word): Wid
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Hannah Rubles
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Unknown
7. AGE: YEARS 70 | MONTHS | DAYS | If LESS than 1 day, ... hrs. or ..... min.

OCCUPATION
8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Farmer
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) Wright Co Mo

FATHER
13. NAME
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Unknown

MOTHER
15. MAIDEN NAME
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

17. INFORMANT (ADDRESS) Howard Lillard Brownfield Mo
18. BURIAL, CREMATION, OR REMOVAL PLACE Cross Roads Mo DATE Mar 11 1939
19. FUNERAL DIRECTOR (ADDRESS) Pohnin Lebanon Mo
20. FILED Apr. 10, 1939 Lester Hicks Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 3 - 9, 1939

22. I HEREBY CERTIFY, That I attended deceased from 4 - 3, 1938 to 7 - 9, 1938
I last saw him alive on 7 - 9 - 1938. Death is said to have occurred on the date stated above, at 11:00 p.m.
The principal cause of death and related causes of importance were as follows:

	Date of onset
Cerebral Hemorrhage	

Other contributory causes of importance:
Varicocele
Bronchial asthma

Name of operation ..... Date of .....
What test confirmed diagnosis? ..... Was there an autopsy? .....

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) Roland E Gaston, M.D.
(Address) Nebo, Mo.

SUPPLEMENTARY

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

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAW.