

FILED APR 8 1940

STANDARD CERTIFICATE OF DEATH

State File No. \_\_\_\_\_

Registration District No. 818

Primary Registration District No. 57-62-6067

Registrar's No. 32

1. PLACE OF DEATH:

(a) County Scott, Mississippi  
 (b) City or town Near-Benton, Mo.  
 (If outside city or town limits, write "RURAL" and name of township)  
 (c) Name of hospital or institution:  
Died enroute to hospital- 3  
 (If not in hospital or institution, write street number or location)  
 (d) Length of stay: In hospital or institution \_\_\_\_\_  
 In this community Flew minutes (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Mississippi  
 (c) City or town Rural- Tywappity township  
 (If outside city or town limits, write "RURAL")  
 (d) Street No. 4 1/2 mi. North of Charleston, Mo  
 (If rural, give location)  
 (e) If foreign born, how long in U. S. A. \_\_\_\_\_ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH, Month Feb. day 29th.  
 year 1940 hour 6 minute 45 P.M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_, 19\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_;

that I last saw him \_\_\_\_\_ alive on \_\_\_\_\_, 19\_\_\_\_; and that death occurred on the date and hour stated above.

Immediate cause of death Enroute to hospital patient died from loss of blood Duration About 4 hrs

Due to shock  
 Due to Placental Praevia

Other conditions Pregnancy 8 mo  
 (Include pregnancy within 3 months of death)

Major findings: \_\_\_\_\_  
 Of operations: \_\_\_\_\_  
 Of autopsy: none

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) \_\_\_\_\_  
 (b) Date of occurrence \_\_\_\_\_  
 (c) Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)  
 (d) Did injury occur in or about home, on farm, in industrial place, in public place? \_\_\_\_\_

While at work? \_\_\_\_\_ (Specify type of place) (e) Means of injury \_\_\_\_\_

23. Signature John F. Hummel, M.D.  
 Address Charleston, Mo Date signed 3-1-40

8. (a) PRINT FULL NAME Albirtha Pittman

3. (b) If veteran, name war X X X 3. (c) Social Security No. X X X

4. Sex Female 5. Color or race Col. 6. (a) Single, widowed, married, divorced married

6. (b) Name of husband or wife George Pittman 6. (c) Age of husband or wife if alive 29 years

7. Birth date of deceased Oct. 12 1912  
 (Month) (Day) (Year)

8. AGE: Years 27 Months 4 Days 17 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

9. Birthplace Lexconder Tenn.  
 (City, town, or county) (State or foreign country)

10. Usual occupation House wife

11. Industry or business House keeping

12. Name Charles Rhodes

13. Birthplace Whiteville Tenn.  
 (City, town, or county) (State or foreign country)

14. Maiden name Addie Rhodes

15. Birthplace not known Tenn.  
 (City, town, or county) (State or foreign country)

16. (a) Informant George Pittman

(b) Address R. 2. Box 145- Charleston.

17. (a) Burial (b) Date thereof 3-3-40  
 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Oak Grove-Charleston

18. (a) Signature of funeral director John F. Hummel

(b) Address Charleston, Mo.

19. (a) 3-9-40 (b) J. S. Hemen  
 (Date received local registrar) (Registrar's signature)

WRITE PLAINLY--USE UNFADING BLACK INK--MAKE A PERMANENT RECORD

144

RECEIVED

District Health Officer No.

District File Number 440-8

Date Filed 4/4/40

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

John F. Hummel

Licensed Embalmer No. 3857

P. O. Address Charleston

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.

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

State File No. 126027

Registration District No. ....

Primary Registration District No. ....

Registrar's No. 22

1. PLACE OF DEATH:

(a) County Scott  
(b) City or town .....  
(c) Name of hospital or institution  
In route to Hosp.  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution..... (Specify whether  
In this community..... years, months or days)

3. (a) PRINT FULL NAME Alvirtha Pittman

3. (b) If veteran, name war..... 3. (c) Social Security No.....

4. Sex F 5. Color or race A 6. (a) Single, widowed, married, divorced m

6. (b) Name of husband or wife..... 6. (c) Age of husband, or wife, if alive..... year

7. Birth date of deceased..... (Month) (Day) (Year)

8. AGE: Years 27 Months 4 Days 17 If less than one day..... hr..... min.

9. Birthplace..... (City, town, or county) (State or foreign country)

10. Usual occupation.....

11. Industry or business.....

MOTHER FATHER { 12. Name.....

{ 13. Birthplace..... (City, town, or county) (State or foreign country)

{ 14. Maiden name.....

{ 15. Birthplace..... (City, town, or county) (State or foreign country)

16. (a) Informant.....

(b) Address.....

17. (a) (Burial, cremation, or removal)..... (b) Date thereof..... (Month) (Day) (Year)

(c) Place: burial or cremation.....

18. (a) Signature of funeral director.....

(b) Address.....

19. (a) (Date received local registrar)..... (b) (Registrar's signature).....

2. USUAL RESIDENCE OF DECEASED:

(a) State..... (b) County.....  
(c) City or town..... (If outside city or town limits write "RURAL")  
(d) Street No..... (If rural, give location)  
(e) If foreign born, how long in U. S. A.?..... years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb day 29 year 42 hour..... minute..... M.

21. I hereby certify that I attended the deceased from....., 19....., to....., 19.....; that I last saw h..... alive on....., 19....., and that death occurred on the date and hour stated above.

Immediate cause of death: Loss of blood - shock  
Placenta previa

Due to.....  
Due to.....  
Other conditions: Pregnancy 8 mo  
(Include pregnancy within 1 months of death)

Major findings: Of operations.....

Of autopsy.....

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify).....

(b) Date of occurrence.....

(c) Where did injury occur?..... (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place?

While at work?..... (Specify type of place) (e) Means of injury.....

23. Signature John F. Nunnlee (M. D. or other).....

Address..... Date signed.....

SUPPLEMENTARY

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

1940

S-12602