

S. No. 2
M-8-43
F. 5-17-39
PI X37823

FILED JUN 3 1944
Registration District No. 2

Primary Registration District No. 6225

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

1. PLACE OF DEATH:

(a) County Nevada

(b) City or town Nevada

(c) Name of hospital or institution: State Hosp No 3

(d) Length of stay: In hospital or institution _____

In this community 2 years 11 mo 30 day (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson

(c) City or town Kansas City

(d) Street No. 3252 Broadway

(e) Citizen of foreign country? no (Yes or No)

If yes, name country _____

3. (a) PRINT FULL NAME HARRIETT- PITT.

3. (b) If veteran, name war no

3. (c) Social Security No. none

4. Sex fem | 5. Color or race wh.

6. (a) Single, widowed, married, divorced married

6. (b) Name of husband or wife Ellis E Pitt

6. (c) Age of husband or wife if alive unk years

7. Birth date of deceased Oct 16 1888

8. AGE: Years 55 Months 7 Days 4 If less than one day - hr. - min.

9. Birthplace Midway Kentucky

10. Usual occupation formerly housewife

11. Industry or business none

12. Name James M. Coz

13. Birthplace unknown Kentucky

14. Maiden name Martha Michael

15. Birthplace unknown Kentucky

16. (a) Informant Records State Hosp

(b) Address Nevada, Mo.

17. (a) Removal (b) Date thereof 5 20 44

(c) Place: burial or cremation Kansas City, Mo.

18. (a) Signature of funeral director Tracy Thompson

(b) Address Nevada, Mo.

19. (a) 5-20-44 (b) Fozel B. Bewick

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 20 year 1944 hour 5 minute 0 M.

21. I hereby certify that I attended the deceased from May 21, 1941 to May 20, 1944

that I last saw her alive on May 20, 1944 and that death occurred on the date and hour stated above.

Immediate cause of death Paresis

Due to 30 hr

Due to _____

Other conditions With Psychosis

Major findings: Of operations no operation

Of autopsy no autopsy

22. If death was due to external causes, fill in the following: No.

(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 Paul L. Barone (M. D. or other) _____

Address State Hosp No 3 Date signed May 20/44

Duration _____

PHYSICIAN _____

Underline the cause to which death should be charged statistically.

RECEIVED
District Health Officer No. 7,
District File Number 5-44-681
Date Filed 6-2-44

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 me
....., Registered Apprentice No. 1768
working under my personal supervision.

Signed L. O. Terry
Licensed Embalmer No.
P. O. Address Needa 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 this body is not embalmed, fact should be so stated above.