

Registration District No. \_\_\_\_\_

318

Primary Registration District No. \_\_\_\_\_

1003

Registrar's No. \_\_\_\_\_

1. PLACE OF DEATH:

(a) County \_\_\_\_\_  
(b) City or town St. Louis, Missouri  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
1528 North Grand Avenue, /  
(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

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County 661  
(c) City or town St. Louis  
(If outside city or town limits, write "RURAL")  
(d) Street No. 1528 North Grand Ave. / / /  
(If rural, give location)  
(e) Citizen of foreign country? 0 (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME William Pitts

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

4. Sex male 5. Color or race white 6. (a) Single, widowed, married, divorced, single  
6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_ years  
7. Birth date of deceased April 27 1899  
(Month) (Day) (Year)

8. AGE:  Years 46  Months 0  Days 15  If less than one day  
hr. \_\_\_\_\_ min. \_\_\_\_\_

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

10. Usual occupation Miner

11. Industry or business \_\_\_\_\_

MOTHER FATHER { 12. Name Thomas Pitts  
13. Birthplace Dent Missouri  
(City, town, or county) (State or foreign country)  
14. Maiden name Edda May Weaver  
15. Birthplace Shannon Missouri  
(City, town, or county) (State or foreign country)

16. (a) Informant Edda May Pitts  
(b) Address 1528 No. Grand Blvd.  
17. (a) Burial (b) Date thereof 5/14/45  
(Burial, cremation, or removal) (Month) (Day) (Year)  
(c) Place: burial or cremation Memorial Park Cemetery

18. (a) Signature of funeral director SULLIVAN BRO'S  
(b) MAY 15 1945 2849 No. Euclid Ave.  
19. (a) \_\_\_\_\_ (b) J. F. B. [Signature]  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 12  
year 1945 hour 7:5 minute 21 A M.

21. I hereby certify that I attended the deceased from Feb 26 1945 to May 12 1945  
that I last saw him alive on May 11 1945  
and that death occurred on the date and hour stated above.

Immediate cause of death: Pulmonary Tuberculosis  
Due to \_\_\_\_\_  
Due to \_\_\_\_\_  
Other conditions: bronchial asthma  
(Include pregnancy within 3 months of death)

Duration

Major findings: Of operations \_\_\_\_\_  
Of autopsy \_\_\_\_\_

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) \_\_\_\_\_  
of injury \_\_\_\_\_

23. Signature W. H. White (M. D. or other) \_\_\_\_\_  
Date signed 5-12-45

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

60  
17  
9

Dr. White.

Kingshighway & Maffitt

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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.....

.....  
working under my personal supervision.

Registered Apprentice No. ....

Signed

*Robert L. Bankman*

Licensed Embalmer No. 3553

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, fact should be so stated above.**