

Registration District No. 318

Primary Registration District No. 1003

1. PLACE OF DEATH:

(a) County St. Louis

(b) City or town St. Louis  
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: St. Louis Childrens Hospital  
(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 Illinois (b) County Coles 997

(c) City or town Charleston  
(If outside city or town limits, write "RURAL")

(d) Street No. 223 Taylor  
(If rural, give location) NR 2

(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No) 2

If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME Clifton John Pittman

3. (b) If veteran, name war No

3. (c) Social Security No. None

4. Sex Male

5. Color or race White

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

6. (b) Name of husband or wife \_\_\_\_\_

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

7. Birth date of deceased February 8 1947  
(Month) (Day) (Year)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month February 11  
year 47 hour 10 minute a.m.

21. I hereby certify that I attended the deceased from 2-10-1947 to 2-11-1947  
that I last saw h. alive on 2-11-1947  
and that death occurred on the date and hour stated above.

8. AGE:

Years	Months	Days	If less than one day
<u>0</u>	<u>0</u>	<u>3</u>	hr. _____ min. _____

Immediate cause of death Hydrops foetalis

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions 1/21  
(Include pregnancy within 3 months of death)

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

10. Usual occupation Infant

MOTHER FATHER

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

12. Name Paul C. Pittman

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

14. Maiden name Mary Hazen

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

PHYSICIAN

Major findings: \_\_\_\_\_

Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

Underline the cause to which death should be charged statistically.

16. (a) Informant Mr. Paul Pittman

(b) Address Charleston, Ill.

17. (a) Removal (b) Date thereof 2-12-47  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Charleston, Ill.

18. (a) Signature of funeral director Albert H. Hoppe

(b) Address 4700 Washington Blvd.

19. (a) FEB 13 1947 (b) J. F. Bredak  
(Date received local registrar) (Registrar's signature)

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 J. C. Blottner (M. D. or other) 0

Address 500 N. Kingshighway Date signed \_\_\_\_\_

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

20  
17  
9

0125

**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..... *Elmo R. Cadwell*.....

Licensed Embalmer No..... *4077*.....

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.**