

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED SEP 19 1947
Registration District No. 47

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. _____
Registrar's No. 323

Primary Registration District No. 3005

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD
14
1
21

1. PLACE OF DEATH:
(a) County Callaway
(b) City or town Fulton
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: State Hosp. # 1
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution Since Dec 14-1936
(Specify whether years, months or days)
In this community _____

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County Crawford
(c) City or town _____
(If outside city or town limits, write "RURAL")
(d) Street No. _____
(If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME Bill Pitts
(b) If veteran, name war _____
(c) Social Security No. _____

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month Sept day 9th
year 1947 hour 3 minute 45 P.M.

4. Sex male 5. Color or race white
6. (a) Single, widowed, married, divorced married
(b) Name of husband or wife ? (c) Age of husband or wife if alive ? years
7. Birth date of deceased April 9 1909
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from Jan 1943
to Sept 9 1947
that I last saw him alive on Sept 9 1947
and that death occurred on the date and hour stated above.
Immediate cause of death Pulmonary Tuberculosis
Duration _____

8. AGE: Years 38 Months 5 Days 0
If less than one day hr. _____ min. _____

Due to He had received much treatment for cerebral sinus
Due to _____

9. Birthplace Crawford Co. Mo
(City, town, or county) (State or foreign country)
10. Usual occupation Farm Labor

Other conditions _____
(Include pregnancy within 3 months of death)
Major findings: none done
Of operations _____
Of autopsy not granted

11. Industry or business _____
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)

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? _____
(Specify type of place) (e) Means of injury _____

16. (a) Informant From hospital records
(b) Address Patent and here from State Pen
17. (a) Removal (b) Date thereof 9-11-47
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Slago, Mo
18. (a) Signature of funeral director Shallice Funeral Home
(b) Address 776 E 81 Fulton, Missouri
19. (a) 9-11-1947 (b) Joan Morawick
(Date received local registrar) (Registrar's signature)

Signature P. S. Tate (M. D. or other)
Address State Hosp. # 1 - Fulton Date signed 9-9-47

RECEIVED
District Health Officer No. 9,
District File Number
Date Filed SEP 17 1947

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: *Denzil C. Browning*
Licensed Embalmer No. *2724*
P. O. Address: *Fulton Ave*

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.