

FILED MAY 10 1950

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 15438

BIRTH NO. _____ REG. DIST. NO. 317 PRIMARY REG. DIST. NO. 6076 Registrar's No. 1059

1. PLACE OF DEATH a. COUNTY St. Louis		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY _____	
b. CITY (If outside corporate limits, write RURAL and give OR TOWN Koch (rural))		c. CITY (If outside corporate limits, write RURAL and give township) ST. LOUIS (in this place) OR TOWN St. Louis	
c. LENGTH OF STAY (in this place) 102 days		d. STREET ADDRESS (If rural, give location) 905 Chestnut	
d. FULL NAME OF HOSPITAL OR INSTITUTION Robert Koch Hospital			

3. NAME OF DECEASED (Type or Print) a. (First) Harrison		b. (Middle) -		c. (Last) Pittman		4. DATE OF DEATH (Month) (Day) (Year) April 22, 1950	
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5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Divorced	8. DATE OF BIRTH 12-25-07	9. AGE (in years last birthday) 42	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HRS. Hours _____ Min. _____
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Caterer at Mo. Athletic Club	10b. KIND OF BUSINESS OR INDUSTRY Athletic Club	11. BIRTHPLACE (State or foreign country) Atlanta, Georgia	12. CITIZEN OF WHAT COUNTRY? U.S.A.
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13a. FATHER'S NAME Henry Pittman	13b. MOTHER'S MAIDEN NAME Minnie Kiefer	14. NAME OF HUSBAND OR WIFE Barbara Cowan, divorced
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No	16. SOCIAL SECURITY NO. ??	17. INFORMANT'S SIGNATURE OR NAME Hospital Records, Robt. Koch Hosp.	ADDRESS _____
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18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH 8 mo. (?)
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Pulmonary Tuberculosis		
	II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		

19a. DATE OF OPERATION _____	19b. MAJOR FINDINGS OF OPERATION _____	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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21a. ACCIDENT SUICIDE HOMICIDE (Specify) _____	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) _____	21c. (CITY, TOWN, OR TOWNSHIP) _____ (COUNTY) _____ (STATE) _____
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour) _____ m.	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? _____
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22. I hereby certify that I attended the deceased from 1-10-50, 19____, to 4-22-50, 19____, that I last saw the deceased alive on 4-22-50, 19____, and that death occurred at 4:50A.m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) John W. Beckham, M.D.	23b. ADDRESS Robert Koch Hospital	23c. DATE SIGNED 4-22-50
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24a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	24b. DATE 4-24-1950	24c. NAME OF CEMETERY OR CREMATORY MT. HOPE	24d. LOCATION (City, town, or county) ST. LOUIS, MO. (State) _____
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DATE REC'D BY LOCAL REGISTRAR'S SIGNATURE APR 24 1950 Herbert R. Woube, M.D.	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS _____
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(Licensed Embalmer's Statement on Reverse Side)

WRITE PLAINLY—USING UNFAADING BLACK INK—MAKE A PERMANENT RECORD

No. 300
10-48

M. J. Laughlin

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 _____

Not Embalmed

Student Embalmer No. _____

working under my personal supervision.

Student
Student Embalmer

Signed *James R. Chapman*

Licensed Embalmer No. *4550*

P. O. Address *St. Louis, 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.