

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

FILED NOV 28 1950

State File No. 37920

BIRTH NO. _____ REG. DIST. NO. 264 PRIMARY REG. DIST. NO. 5892 Registrar's No. 36

770

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

1. PLACE OF DEATH a. COUNTY Ozark		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Mo. b. COUNTY Ozark	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Tecumseh		c. LENGTH OF STAY (in this place) 54 yrs.	
d. FULL NAME OF HOSPITAL OR INSTITUTION At Home		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Tecumseh	
		d. STREET ADDRESS (If rural, give location)	

3. NAME OF DECEASED (Type or Print)	a. (First) Hariett	b. (Middle) A.	c. (Last) Pitcock	4. DATE OF DEATH (Month) (Day) (Year) Nov. 15, 1950
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5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed	8. DATE OF BIRTH Feb. 21, 1867	9. AGE (In years last birthday) 83	IF UNDER 1 YEAR 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) Housewife.	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Mo. 10	12. CITIZEN OF WHAT COUNTRY? U. S. A.
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13a. FATHER'S NAME Jacob F. Swafford	13b. MOTHER'S MAIDEN NAME Emmaline Turnbow	14. NAME OF HUSBAND OR WIFE
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No	16. SOCIAL SECURITY NO. (If yes, give war or dates of service) None	17. INFORMANT'S SIGNATURE OR NAME	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, asphyxia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH 1 1/2 yr
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cardiac Decompensation		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Arterial Hypertension DUE TO (c)		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		444X	

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input 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 **Nov 1**, 19**50**, to **Nov 15**, 19**50**, that I last saw the deceased alive on **Nov 13**, 19**50**, and that death occurred at **8 a** m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) W. J. Sherman M.D.	23b. ADDRESS Lanesville, Mo.	23c. DATE SIGNED 10-17-50
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24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE Nov 17	24c. NAME OF CEMETERY OR CREMATORY Lilly Ridge	24d. LOCATION (City, town, or county) (State) Lilly Ridge. Mo.
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DATE REC'D BY LOCAL REG. 11-17-50	REGISTRAR'S SIGNATURE William Copwell	465	25. FUNERAL DIRECTOR'S SIGNATURE Roller Funeral Home	ADDRESS Mt. Home, Ark.
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DIVISION OF HEALTH OF MO.

District No. 5 - Springfield

RECEIVED NOV 25 1950

Dist. File 1150-2322

Date Filed 11-27-50

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.....

..... Student Embalmer No.

working under my personal supervision.

Student
Student Embalmer

Signed John M. Davies.....

Licensed Embalmer No. 4620

P. O. Address Mtn Home Ark.

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.