

FILED JAN 13 1951

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 40204

BIRTH NO. _____ REG. DIST. NO. 88 PRIMARY REG. DIST. NO. 5327 Registrar's No. 38

| | | | |
|--|--|--|--|
| 1. PLACE OF DEATH a. COUNTY CRAWFORD | | 2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE MISSOURI b. COUNTY CRAWFORD | |
| b. CITY (If outside corporate limits, write RURAL and give township) WESCO (UNION) | | c. CITY (If outside corporate limits, write RURAL and give township) WESCO | |
| c. LENGTH OF STAY (in this place) 35 YRS | | d. STREET ADDRESS (If rural, give location) 0 | |
| d. FULL NAME OF (If not in hospital or institution, give street address of location) HOSPITAL OR INSTITUTION | | | |

| | | | | | |
|---|---------------------------|---|---|--|-------------------------------------|
| 3. NAME OF DECEASED a. (First) ANDREW b. (Middle) PITTS c. (Last) | | | 4. DATE OF DEATH (Month) (Day) (Year) DEC. 4, 1950 | | |
| 5. SEX MALE | 6. COLOR OR RACE WHITE | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) MARRIED | 8. DATE OF BIRTH MARCH 6, 1859 | 9. AGE (In years last birthday) 91 | 10. IF UNDER 1 YEAR Days 8 |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FARMER | | 10b. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) SCOTIA, MISSOURI | | 12. CITIZEN OF WHAT COUNTRY? USA |
| 13a. FATHER'S NAME UNKNOWN | | 13b. MOTHER'S MAIDEN NAME UNKNOWN | | 14. NAME OF HUSBAND OR WIFE ELLEN PITTS | |

| | | | | |
|--|---------------------------------|--|--|---------|
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO | 16. SOCIAL SECURITY NO. NONE | 17. INFORMANT'S SIGNATURE OR NAME SONIA PITTS, ST. JAMES, MO. | | 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, asthma, etc. It means the disease, injury, or complication which caused death. | MEDICAL CERTIFICATION | | | INTERVAL BETWEEN ONSET AND DEATH 1 month |
| | I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Arteriosclerotic Heart Disease | | | |
| | ANTECEDENT CAUSES Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Arteriosclerosis DUE TO (c) Auricular Fibrillation | | | |
| II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Avitaminosis - Malnutrition | | | 4200 | |

| | | | |
|---|--|---|---|
| 19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 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) | 21f. HOW DID INJURY OCCUR? |
| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) | 21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | |

22. I hereby certify that I attended the deceased from 11-7, 1950, to 11-7, 1950, that I last saw the deceased alive on 11-7, 1950, and that death occurred at 8 - A. m., from the causes and on the date stated above.

| | | | |
|---|----------------------|--|--|
| 23a. SIGNATURE John Charles Doubek Jr. M.D. | (Degree or title) | 23b. ADDRESS Steelville, Mo. | 23c. DATE SIGNED 12-8-50 |
| 24a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL | 24b. DATE 12/6/50 | 24c. NAME OF CEMETERY OR CREMATORY SLIGO CEMETERY | 24d. LOCATION (City, town, or county) (State) SLIGO, CEMETERY |

| | | | |
|------------------------------------|--------------------------------------|---|----------------------------|
| DATE REC'D BY LOCAL REG. 1-5-51 | REGISTRAR'S SIGNATURE [Signature] | 25. FUNERAL DIRECTOR'S SIGNATURE THOMAS S. HALBERT | ADDRESS STEELVILLE, MO. |
|------------------------------------|--------------------------------------|---|----------------------------|

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

280
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File No. _____
DISTRICT HEALTH OFFICE No. 4

JAN 9 1951

RECEIVED

JUN 23 1954

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

Thomas S. Halder

Licensed Embalmer No. 4337

P. O. Address Steelville, 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.