

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

4361

State File No.

FILED MAR 7 1955

BIRTH NO. _____ REG. DIST. NO. 99 PRIMARY REG. DIST. NO. 5377 Registrar's No. 6

320
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH a. COUNTY DeKalb		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Mo. b. COUNTY DeKalb	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Fairport Grant Sup		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Fairport	
c. LENGTH OF STAY (If this place) Life		d. STREET ADDRESS (If rural, give location) South edge of town	
d. FULL NAME OF HOSPITAL OR INSTITUTION Home In Town			

3. NAME OF DECEASED (Type or Print) a. (First) Mae	b. (Middle) Drucilla	c. (Last) Pittman	4. DATE OF DEATH (Month) (Day) (Year) 2 - 11 55
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5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH 11-26-1885	9. AGE (In years) (Month) (Day) (Year) 69	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Hours	IF UNDER 24 HRS. 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 Home	11. BIRTHPLACE (State or foreign country) Mo.	12. CITIZEN OF WHAT COUNTRY USA USA
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13a. FATHER'S NAME Thomas Davis	13b. MOTHER'S MAIDEN NAME Ellen Cunningham	14. NAME OF HUSBAND OR WIFE Carl Pittman
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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) XXXXXXXXXXXX	17. INFORMANT'S SIGNATURE OR NAME Carl Pittman	ADDRESS Fairport Mo.
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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
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Carcinoma of liver		
	ANTECEDENT CAUSES Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____		
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 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 1/26, 1955 to 2/11, 1955, that I last saw the deceased alive on 2/11, 1955, and that death occurred at 12:45 p.m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) W. Harold Fowler, M.D.	23b. ADDRESS Maysville Mo	23c. DATE SIGNED 2/12/55
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24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE 2-13-55	24c. NAME OF CEMETERY OR CREMATORY Fairport	24d. LOCATION (City, town, or county) (State) Fairport Mo
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DATE REC'D BY LOCAL REG. 2-21-55	REGISTRAR'S SIGNATURE Russ Davidson	25. FUNERAL DIRECTOR'S SIGNATURE John B...	ADDRESS Maysville Mo
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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.

Signed.....

John Brown

Signed.....
Student Embalmer

Licensed Embalmer No. 3933
Maysville Mo.

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.