

Dept. Health,
ec., & Welfare
I. S. Public
Health Service

FILED DEC 2 - 1957

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

39325

STATE FILE NUMBER
1287

Registration District No. 42 Primary Registration District No. 1000

Registrar's No. 1287

V. S. 300
Rev. 1-57

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|--|------------------------|---|---|
| 1. PLACE OF DEATH a. COUNTY Buchanan | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY DeKalb | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) St. Joseph Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | | c. CITY OR TOWN Fairport Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Mo. Meth. Hospital Length of stay in lb 2 weeks | | d. STREET ADDRESS (If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First Middle Last Carl S. Pittman | | | 4. DATE OF DEATH Month Day Year November 20, 1957. |
| 5. SEX Male | 6. COLOR OR RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOW <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH Jan. 19, 1875 |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer | | 10b. KIND OF BUSINESS OR INDUSTRY Farm | 9. AGE (In years birthday) 82 IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min. |
| 11. BIRTHPLACE (City and state or country) Missouri. | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 13a. FATHER'S NAME William Pittman | | 13b. MOTHER'S MAIDEN NAME Rebecca Stephens | |
| 14. NAME OF HUSBAND OR WIFE Unknown | | 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, name or unknown) (If yes, give war or dates of service) No | |
| 16. SOCIAL SECURITY NO. none | | 17. INFORMANT Address William Pittman Maysville, Mo. | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Ruptured esophageal varices Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) Cirrhosis of the liver DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a). Carcinoma of the prostate | | | INTERVAL BETWEEN ONSET AND DEATH 5 days Unknown |
| 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20a. ACCIDENT SUICIDE HOMICIDE <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> | |
| 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.): | | 20c. TIME OF INJURY Hour Month, Day, Year a.m. p.m. | |
| 20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE WORK AT <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | |
| 20f. CITY, TOWN, OR LOCATION | | COUNTY STATE | |
| 21. I attended the deceased from Oct. 29, 1957 to Nov. 20, 1957 and last saw ^{her} him alive on Nov. 20, 1957 Death occurred at 10:05 A. m. on the date stated above; and to the best of my knowledge, from the causes stated. | | | |
| 22a. SIGNATURE <i>William Pittman M.D.</i> | | 22b. ADDRESS 706 Francis St. Joseph, Mo. | |
| 22c. DATE SIGNED Nov. 25, '57 | | 23a. BURIAL, CREMATION, REMOVAL (Specify) Removal | |
| 23b. DATE Nov. 20, 1957. | | 23c. NAME OF CEMETERY OR CREMATORY Fairport Cemetery | |
| 23d. LOCATION (City, town, or county) Fairport, Missouri. | | 23e. (State) | |
| 24. FUNERAL DIRECTOR Meierhoffer-Fleeman, Inc., St. Joseph, Mo. | | 25. DATE RECD. BY LOCAL REG. Nov. 27, 1957 | |
| 26. REGISTRAR'S SIGNATURE <i>Mrs. Robert Fulton</i> | | | |

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related.

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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.

Student Signature of Student Embalmer

Signed *Bill Chavez*

Licensed Embalmer No. 4679

P. O. Address St. Joseph, 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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.