

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-016740
STATE FILE NUMBER

FILED JUN 1 1959 Registration District No. 38 Primary Registration District No. 3006 Registrar's No. 247

1. PLACE OF DEATH a. COUNTY <u>Boone</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Cass</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Columbia</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>Harrisonville</u> ⁰¹⁹⁶
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>ummc</u>		Length of stay in lb <u>4hrs 56m</u>	d. STREET ADDRESS (If outside, give location) <u>E. Elm. Dead End St.</u>
3. NAME OF DECEASED (Type or print) First <u>Betty</u> Middle <u>Ann</u> Last <u>Pittes</u>			4. DATE OF DEATH Month <u>May</u> Day <u>28</u> Year <u>1959</u>
5. SEX <u>Female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 28, 1959</u>
9. AGE (In years last birthday)		IF UNDER 1 YEAR Months <u>4</u> Days <u>56</u>	IF UNDER 24 HRS. Hours <u>4</u> Min <u>56</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) <u>Columbia, Mo.</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13a. FATHER'S NAME	
13b. MOTHER'S MAIDEN NAME <u>Martha Belle Andross</u>		14. NAME OF HUSBAND OR WIFE	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	17. INFORMANT <u>Mother</u> Address <u>see above</u>
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac Failure</u>			INTERVAL BETWEEN ONSET AND DEATH <u>5 min</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Obstetric Complication-Shoulder Dystocia</u>			4 hrs 56 min
DUE TO (c) <u>with complete Anoxia for 7 min.</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>7610</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> <u>2</u>
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <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 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 <u>May 28, 1959</u> to <u>May 28, 1959</u> and last saw <u>her</u> alive on <u>May 28, 1959</u> Death occurred at <u>3:59</u> p.m. on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <u>Ernest Van Leuven M.D.</u> (Degree or title)		22b. ADDRESS <u>Univ. Hosp - Columbia, Mo.</u>	22c. DATE SIGNED <u>5/29/59</u>
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE <u>May 29, 1959</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Orient Cemetery Harrisonville, Mo.</u>	23d. LOCATION (City, town, or county) (State) <u>Harrisonville, Mo.</u>
24. FUNERAL DIRECTOR <u>Hammenburg Harrisonville, Mo.</u>	25. DATE RECD. BY LOCAL REG. <u>May 29, 1959</u>	26. REGISTRAR'S SIGNATURE <u>Mrs R.E. Palmer</u>	

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.

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
Signature of Student Embalmer

Infant

Signed *Ernest Remmenburg*

Licensed Embalmer No. *3368*

P. O. Address *Harrisonville*

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.