

r. Health,  
& Welfare  
Public  
h Service

S. 300  
1-57

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.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE  
MEDICAL CERTIFICATION

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

59-027885

STATE FILE NUMBER

FILED VS JUL 21 1959

Registration District No. 355 Primary Registration District No. 6202 Registrar's No. \_\_\_\_\_

|   |                                  |   |  |   |  |
|---|----------------------------------|---|--|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Texas</u>   |                                  |   | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <u>Missouri</u> b. COUNTY <u>Texas</u> |   |  |
| b. CITY (If outside corporate limits, give TOWNSHIP only)<br>OR TOWN <u>Summersville (Cape 11)</u><br><u>760</u>  |                                  | Inside Limits<br>Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>  | c. CITY OR TOWN <u>Summersville</u>  |   | Inside Limits<br>Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>     |
| c. FULL NAME OF (IF NOT in hospital, give location)<br>HOSPITAL OR INSTITUTION <u>Home</u>  |                                  | Length of stay in lb  | d. STREET ADDRESS (If outside, give location)<br><u>1070</u>   |   | Reside on Farm<br>Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>    |
| 3. NAME OF DECEASED (Type or print)<br>First <u>John</u> Middle <u>Allen</u> Last <u>Pitts</u>  |                                  |   | 4. DATE OF DEATH<br>Month <u>June</u> Day <u>29</u> Year <u>1959</u>   |   |  |
| 5. SEX<br><u>male</u>   | 6. COLOR OR RACE<br><u>White</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><u>Dec. 13, 1880</u>   | 9. AGE (In years last birthday)<br><u>78</u>                        | IF UNDER 1 YEAR<br>Months _____ Days _____<br>IF UNDER 24 HRS.<br>Hours _____ Min. _____ |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>Farming</u>   |                                  | 10b. KIND OF BUSINESS OR INDUSTRY   |  | 11. BIRTHPLACE (City and state or country)<br><u>South Carolina</u> | 12. CITIZEN OF WHAT COUNTRY?<br><u>USA</u>   |
| 13a. FATHER'S NAME<br><u>Nelmeth Pitts</u>  |                                  | 13b. MOTHER'S MAIDEN NAME<br><u>Josephine Porter</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<br>Address _____                                      |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Acute Circulatory Failure</u><br>Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. }<br>DUE TO (b) <u>Coronary thrombosis with myocardial infarction</u><br>DUE TO (c) <u>Arteriosclerosis &amp; atherosclerosis</u> |                                  |   |  |   | INTERVAL BETWEEN ONSET AND DEATH   |
| 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<br>Hour _____ 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>1954</u> to <u>1959</u> and last saw <u>him</u> alive on <u>June 29-1959</u><br>Death occurred at <u>9:00 P.M.</u> on the date stated above; and to the best of my knowledge, from the causes stated.   |                                  |   |  |   |  |
| 22a. SIGNATURE (Degree or title)<br><u>Dr. Lavere Sampson, D.O.</u>   |                                  |   | 22b. ADDRESS<br><u>Summersville Mo</u>   |   | 22c. DATE SIGNED<br><u>7-10-59</u>   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><u>Burial</u>  |                                  | 23b. DATE<br><u>7/2/59</u>  | 23c. NAME OF CEMETERY OR CREMATORY<br><u>Riley Cemetery</u>  |   | 23d. LOCATION (City, town, or county) (State)<br><u>Summersville, Missouri</u>           |
| 24. FUNERAL DIRECTOR<br><u>Quinlan Funeral Home</u>   |                                  | ADDRESS<br><u>Mtn. View, Mo.</u>  |  | 25. DATE RECD. BY LOCAL REG.<br><u>7-17-59</u>                      | 26. REGISTRAR'S SIGNATURE<br><u>Anna Roberts</u>   |

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 *Richard A Norton* .....

Licensed Embalmer No. *5029* .....  
P. O. Address. *Mt. View, N.C.*

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.