

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-041389

NOV 3 0 1960

Registration District No. 75 Primary Registration District No. 3015 Registrar's No. 124 STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY <u>Clinton</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Daviess</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Cameron</u>		Length of stay in 1b <u>1 Day</u>	c. CITY OR TOWN <u>Gallatin</u> Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Cameron Community Hosp.</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>---</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <u>Harley</u> Middle <u>Marion</u> Last <u>Pittman</u>			4. DATE OF DEATH Month <u>November</u> Day <u>6</u> Year <u>1960</u>			
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5. SEX <u>Male</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>12-3-1894</u>	9. AGE (last birthday) <u>65</u>	IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u>	IF UNDER 24 HR Hours <u>  </u> Min. <u>  </u>
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Station Agent</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>Railroad</u>	11. BIRTHPLACE (City and state or country) <u>Harrison Co., Mo.</u>	12. CITIZEN OF WHAT COUNTRY <u>USA</u>
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13a. FATHER'S NAME <u>Marion A. Pittman</u>	13b. MOTHER'S MAIDEN NAME <u>Anna Williams</u>	14. NAME OF HUSBAND OR WIFE <u>---</u>
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>	16. SOCIAL SECURITY NO. <u>486-01-9399</u>	17. INFORMANT <u>Everett Pittman, Platsburg, Mo.</u>	Address
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a) <u>Acute congestive myocardial failure</u>		<u>Unknown</u>
Cerebral vascular hemorrhage with left hemiplegia 2 days		
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b)	
	DUE TO (c)	

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
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19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	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.)
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20c. TIME OF INJURY Hour <u>  </u> Month, Day, Year <u>  </u>	20d. INJURY OCCURRED WHILE AT WORK <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 <u>  </u> COUNTY <u>  </u> STATE <u>  </u>
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21. I attended the deceased from Nov. 4, 1960 to Nov. 6, 1960 and last saw her/him alive on Nov. 5, 1960  
Death occurred at 1:45 P. m on the date stated above, and to the best of my knowledge, from the causes stated:

22a. SIGNATURE <u>Edward Cox</u> (Degree or title)	22b. ADDRESS <u>Gallatin, Mo</u>	22c. DATE SIGNED <u>11/6/60</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>11-8-1960</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Brown Cemetery</u>	23d. LOCATION (City, town, or county) (State) <u>Gallatin, Missouri</u>
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24. FUNERAL DIRECTOR <u>L.O. Dickerson</u> Hope Funeral Home, Gallatin, Mo.	25. DATE RECD. BY LOCAL REG. <u>Nov 22 1960</u>	26. REGISTRAR'S SIGNATURE <u>Francis D Crawford</u>
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DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

DEC 3 1960

DEC 30 1960

**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_, or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_, working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed L. O. Riches

Licensed Embalmer No. 3307

P. O. Address Hollister

**Note:** The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to do so 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.