

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. _____

FILED NOV 8 1961

DATE AMENDED

INSTEAD OF

ITEM NO. SHOULD READ

DOCUMENT

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MO.</u> b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>ST. LOUIS MISSOURI</u>		c. CITY OR TOWN <u>ST. LOUIS</u>	
Length of stay in 1b		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>BARNES HOSPITAL</u>		d. STREET ADDRESS (If outside, give location) <u>4308 McPHERSON AVE.</u>	
Yes <input type="checkbox"/> No <input type="checkbox"/>		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>LOLA VIRGINIA CHITTICK</u>			4. DATE OF DEATH Month Day Year <u>OCTOBER 23 1961</u>
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>6-21-1887</u>
9. AGE (last birthday) <u>74</u>		IF UNDER 1 YEAR Months Days	IF UNDER 24 HR Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWORK</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>AT HOME</u>	11. BIRTHPLACE (City and state or country) <u>DENNISON, TEXAS</u>
12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>		13a. FATHER'S NAME <u>CHARLES KNIGHT</u>	
13b. MOTHER'S MAIDEN NAME <u>MAGGIE SIMMS</u>		14. NAME OF HUSBAND OR WIFE <u>LATE BARNEY CHITTICK</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO</u> <u>NONE</u>			17. INFORMANT Address <u>Arlington K. Reed 5170 LINDEN-DULUTH, MINN.</u>
18. CAUSE OF DEATH (Enter only one cause per line for PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>RHEUMATIC HEART DISEASE WITH CONGESTIVE HEART FAILURE</u>			INTERVAL BETWEEN ONSET AND DEATH <u>40 YEARS</u>
DUE TO (b) _____			PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown
DUE TO (c) _____			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input checked="" 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.)			
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year			
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		COUNTY	STATE
21. I attended the deceased from <u>JULY 27, 1945</u> to <u>OCTOBER 21, 1961</u> and last saw her/him alive on <u>OCTOBER 21, 1961</u> Death occurred at <u>1:30 P.M.</u> m on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <u>C. S. Smith, M.D.</u> (Degree or title)		22b. ADDRESS <u>BARNES HOSPITAL</u>	
22c. DATE SIGNED <u>10/24/61</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE <u>OCT. 27, 1961</u>	23c. NAME OF CEMETERY OR CREMATORY <u>BELLEFONTAINE CEMETERY</u>	23d. LOCATION (City, town, or county) (State) <u>ST. LOUIS, MO.</u>
24. FUNERAL DIRECTOR <u>KRIEGSHAUSER 4228 S. KINGSHIGHWAY BLVD.</u>		25. DATE RECD. BY LOCAL REG. <u>OCT 26 1961</u>	26. REGISTRAR'S SIGNATURE <u>Carl Smith, M.D.</u>

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

EMERALD CITY

EMERALD CITY

EMERALD CITY

EMERALD CITY

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 William B White

Licensed Embalmer No. 4291

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.