

FILED SEP 17 1962 STANDARD CERTIFICATE OF DEATH

STATE FILE NUMBER

Registration District No. 251

Primary Registration District No.

Registrar's No. 216

V. S. 300

Rev. 1-57

0740

The funeral director is responsible for the proper completion of the entire certificate. This includes securing the medical certification in the specific manner required by 193.140 MoRS 1949. 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

1. PLACE OF DEATH a. COUNTY <u>Madison Mo.</u>		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>Clairmont Mo</u>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>NORTHGORE 0740</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>Walter Thurston 2 Mo.</u>		Length of stay in 1b	d. STREET ADDRESS (If outside, give location) Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>JAMES</u> Middle <u>ROSS</u> Last <u>PITZER</u>			4. DATE OF DEATH Month <u>8</u> Day <u>27</u> Year <u>62</u>
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 2. WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>MARCH 9, 1879</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FARMING</u>		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) <u>53</u> IF UNDER 1 YEAR: Months Days Hours Min. IF UNDER 24 HRS.
11. BIRTHPLACE (City and state or country) <u>NEBR</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13a. FATHER'S NAME <u>Unknown</u>		13b. MOTHER'S MAIDEN NAME <u>Unknown</u>	14. NAME OF HUSBAND OR WIFE <u>JENNIE</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>		16. SOCIAL SECURITY NO. <u>NO</u>	17. INFORMANT Address <u>x Byron Scotton</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>Uremia.</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Art riolar nephrosclerosis and low r urinary tract obstruction du to prostatic hyp rtrophy. 446X</u> DUE TO (c) <u>Arteriosclerosis.</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Uroscpsis with asc ending infection of urinary tract.</u>			INTERVAL BETWEEN ONSET AND DEATH <u>few days.</u> s v. yrs. sev. yrs.
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>July 20, 1962.</u> to <u>Aug. 27, 1962</u> and last saw <u>her</u> alive on <u>Aug. 10, 1962.</u> Death occurred at <u>Aug. 27, 1962:10; A</u> m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <u>Mansfield</u> (Degree or title) <u>D.O.</u>		22b. ADDRESS <u>Elmo, Mo.</u>	22c. DATE SIGNED <u>Sep. 5, 62</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>aug 29-62</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Malvern</u>	23d. LOCATION (City, town, or country) (State) <u>Malvern Iowa</u>
24. FUNERAL DIRECTOR <u>Mansfield - Malvern Ia</u> ADDRESS		25. DATE RECD. BY LOCAL REG. <u>9-8-62</u>	26. REGISTRAR'S SIGNATURE <u>Burns Holt</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 R.W. Mansfield, Student Embalmer No. _____ working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed R.W. Mansfield
Licensed Embalmer No. 1962 Missoula
P. O. Address Malvern Iowa

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.

[Handwritten scribbles]