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DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS  
FILED MAY 25 1945  
Registration District No. 253

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

17703

State File No. ....

Primary Registration District No. 4384

Registrar's No. ....

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

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1. PLACE OF DEATH:  
(a) County Nodaway  
(b) City or town Skidmore  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: \_\_\_\_\_  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 1 year  
In this community 1 year  
years, months or days (Specify whether)

2. USUAL RESIDENCE OF DECEASED:  
(a) State Missouri (b) County Nodaway  
(c) City or town Skidmore  
(If outside city or town limits, write "RURAL")  
(d) Street No. \_\_\_\_\_  
(If rural, give location)  
(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME Carl Walter Pitts  
3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. 489-14-3393

MEDICAL CERTIFICATION  
20. DATE OF DEATH: Month April day 20  
year 1945 hour 5 minute A.M.

4. Sex male 5. Color or race white  
6. (a) Single, widowed, married, divorced single  
6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_ years  
7. Birth date of deceased April 27, 1896  
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from 4-2-45 to 4-20-45  
that I last saw him alive on 4-18-45  
and that death occurred on the date and hour stated above.

8. AGE: Years 48 Months 11 Days 23 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

Immediate cause of death Angina Pectoris  
Duration \_\_\_\_\_

9. Birthplace Quitman Missouri  
(City, town, or county) (State or foreign country)

Due to \_\_\_\_\_  
Due to \_\_\_\_\_

10. Usual occupation \_\_\_\_\_

Other conditions (Include pregnancy within 3 months of death) \_\_\_\_\_

11. Industry or business \_\_\_\_\_

Major findings: Of operations \_\_\_\_\_ Of autopsy \_\_\_\_\_

12. Name William Pitts

PHYSICIAN \_\_\_\_\_

13. Birthplace Ind. /  
(City, town, or county) (State or foreign country)

14. Maiden name Olive Shapley

15. Birthplace Mich. /  
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Olive Shapley  
(b) Address Skidmore Mo.

17. (a) burial (b) Date thereof \_\_\_\_\_  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Quitman cemetery

18. (a) Signature of funeral director: Price Funeral Home

(b) Address Maryville Mo  
19. (a) 4-22-45 (b) Mrs. John Roehenbuhl  
(Date received local registrar) (Registrar's signature)

22. If death was due to external causes, fill in the following:  
(a) Accident, suicide, or homicide (specify) \_\_\_\_\_  
(b) Date of occurrence \_\_\_\_\_  
(c) Where did injury occur? \_\_\_\_\_ (City or town) (County) (State)  
(d) Did injury occur in or about home, on farm, in industrial place, in public place? \_\_\_\_\_  
(Specify type of place)

23. Signature H. G. Bixton (M. D. or other) MD  
Address Skidmore, Mo. Date signed 4/21/45

**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.....  
....., Registered Apprentice No.....  
working under my personal supervision.

Signed.....

*John W. Price*

Licensed Embalmer No. *4281*

P. O. Address *Maryville Mo*

**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 this body is not embalmed, fact should be so stated above.**

Registration District No. 253

Primary Registration District No. 4384

Registrar's No. \_\_\_\_\_

1. PLACE OF DEATH:

(a) County no dayray  
(b) City or town skidmore  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether \_\_\_\_\_)

In this community \_\_\_\_\_  
years, months or days

3. (a) PRINT FULL NAME Carl W. Pitts

3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

4. Sex m 5. Color or race w 6. (a) Single, widowed, married, divorced \_\_\_\_\_

6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_

7. Birth date of deceased April 27 (Month) (Day) (Year)

8. AGE: Years 48 Months 4 Days 12 If less than one day hr. \_\_\_\_\_ min. \_\_\_\_\_

9. Birthplace \_\_\_\_\_ (City, town, or county) (State or foreign country) Mo.

10. Usual occupation days work at any time

11. Industry or business odd jobs of any kind

MOTHER FATHER { 12. Name \_\_\_\_\_  
13. Birthplace \_\_\_\_\_ (City, town, or county) (State or foreign country)  
14. Maiden name \_\_\_\_\_  
15. Birthplace \_\_\_\_\_ (City, town, or county) (State or foreign country)

16. (a) Informant \_\_\_\_\_

(b) Address \_\_\_\_\_

17. (a) \_\_\_\_\_ (b) Date thereof \_\_\_\_\_ (Month) (Day) (Year)

(c) Place: burial or cremation \_\_\_\_\_

18. (a) Signature of funeral director \_\_\_\_\_

(b) Address \_\_\_\_\_

19. (a) \_\_\_\_\_ (b) \_\_\_\_\_ (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State \_\_\_\_\_ (b) County \_\_\_\_\_  
(c) City or town \_\_\_\_\_ (If outside city or town limits, write "RURAL")  
(d) Street No. \_\_\_\_\_ (If rural, give location)  
(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April Day 27 Year 1945 hour \_\_\_\_\_ minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_ to \_\_\_\_\_, 19\_\_\_\_; that I last saw him \_\_\_\_\_ all on \_\_\_\_\_, 19\_\_\_\_; and that death occurred on the date and hour stated above. Immediate cause of death \_\_\_\_\_

Duration \_\_\_\_\_

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions \_\_\_\_\_ (Includes pregnancy within 3 months of death)

Major findings: Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) \_\_\_\_\_  
(b) Date of occurrence \_\_\_\_\_  
(c) Where did injury occur? \_\_\_\_\_ (City or town) (County) (State)  
(d) Did injury occur in or about home, on farm, in industrial place, in public place? \_\_\_\_\_

While at work? \_\_\_\_\_ (Specify type of place) (e) Means of injury \_\_\_\_\_

23. Signature \_\_\_\_\_ (M. D. or other)

Address \_\_\_\_\_ Date signed \_\_\_\_\_

SUPPLEMENTARY

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

17703