

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS  
**FILED JAN 21 1946**  
STATE BOARD OF HEALTH OF MISSOURI  
**STANDARD CERTIFICATE OF DEATH**

1679

State File No. \_\_\_\_\_

Registrar's No. **5526**

Registration District No. 149

Primary Registration District No. 1602

**1. PLACE OF DEATH:**  
(a) County Jackson  
(b) City or town Kansas City  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: General Hospital #2  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 1 day  
In this community 26 years  
(Specify whether years, months or days)

**2. USUAL RESIDENCE OF DECEASED:**  
(a) State Missouri (b) County Jackson  
(c) City or town Kansas City  
(If outside city or town limits, write "RURAL")  
(d) Street No. 1822 Grove  
(If rural, give location)  
(e) Citizen of foreign country? No  
If yes, name country \_\_\_\_\_

**3. (a) PRINT FULL NAME** James Pitts  
3. (b) If veteran, name war None  
3. (c) Social Security No. 496-29-0683

**MEDICAL CERTIFICATION**  
20. DATE OF DEATH: Month December day 28, year 1945 hour 7: minute 50 P. M.

4. Sex Male 5. Color or race Negro  
6. (a) Single, widowed, married, divorced Married  
6. (b) Name of husband or wife Jewell Pitts  
6. (c) Age of husband or wife if alive 35 years  
7. Birth date of deceased April 4, 1909  
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from December 27, 1945, to December 28, 1945; that I last saw him alive on December 28, 1945; and that death occurred on the date and hour stated above.

**8. AGE:** Years 36 Months 8 Days 24  
If less than one day hr. \_\_\_\_\_ min. \_\_\_\_\_

Immediate cause of death Acute Congestive Failure  
Due to Isletic Heart disease with Aortic Regurgitation  
Due to \_\_\_\_\_

9. Birthplace Little Rock Arkansas  
(City, town, or county) (State or foreign country)  
10. Usual occupation Laborer  
11. Industry or business None

Other conditions (include pregnancy within 3 months of death) \_\_\_\_\_  
Major findings: Of operations 302  
Of autopsy \_\_\_\_\_

**MOTHER** { 12. Name Will Pitts  
13. Birthplace Arkansas  
(City, town, or county) (State or foreign country)  
**FATHER** { 14. Maiden name Grace Minor  
15. Birthplace Arkansas  
(City, town, or county) (State or foreign country)

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) Means of Injury \_\_\_\_\_

16. (a) Informant Medical Records Librarian  
(b) Address General Hospital #2  
17. (a) Burial (b) Date, thereof 1/5/46  
(Burial, cremation, or removal) (Month) (Day) (Year)  
(c) Place: burial or cremation Lincoln Cemetery  
18. (a) Signature of funeral director Wilkins  
(b) Address 1729 Lydia  
19. (a) 12-31-45 (b) Beatrice Holmes  
(Date received local registrar) (Registrar's signature)

23. Signature H. C. Thomas (M. D. or other)  
Address General Hospital #2 Date signed 12/29/45

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

**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.....

*Lawrence Jones*....., Registered Apprentice No. *378*  
working under my personal supervision.

Signed *J. J. Marlove*.....

Licensed Embalmer No. *3994*.....

P. O. Address *2503 Highland*.....

**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.**