

FILED APR 21 1949
#96222

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH **1003**
318

State File No. **14062**
3255

BIRTH NO. _____ REG. DIST. NO. _____ PRIMARY REG. DIST. NO. _____ Registrar's No. _____

15

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

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Missouri b. COUNTY	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis, Mo.		c. LENGTH OF STAY (In this place) 1	
d. FULL NAME OF HOSPITAL OR INSTITUTION St. Louis City Hospital #1.		d. STREET ADDRESS (If rural, give location) 3219 a Mt. Pleasant St.	

3. NAME OF DECEASED (Type or Print) a. (First) KENNY b. (Middle) c. (Last) PITT			4. DATE OF DEATH (Month) (Day) (Year) April 10, 1949				
5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH 9/8/86	9. AGE (In years last birthday) 62	IF UNDER 1 YEAR Months 7	IF UNDER 24 HOURS Days 2	IF UNDER 18 MIN. Hours 2
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Parkkeeper		10b. KIND OF BUSINESS OR INDUSTRY Parkkeeper in City		11. BIRTHPLACE (State or foreign country) Illinois		12. CITIZEN OF WHAT COUNTRY? U.S.	

13a. FATHER'S NAME William Pitt	13b. MOTHER'S MAIDEN NAME Bertha Jackson	14. NAME OF HUSBAND OR WIFE Ida B. Pitt
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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) No	16. SOCIAL SECURITY NO. 495-32-0403	17. INFORMANT'S SIGNATURE OR NAME Ida B. Pitt	ADDRESS 3219 a Mt. Pleasant St.
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18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). *This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.		I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Med. Cert. See Advanced		INTERVAL BETWEEN ONSET AND DEATH
ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____		II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		

20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?
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22. I hereby certify that I attended the deceased from **4/7/49**, 19____, to **4/10/49**, 19____, that I last saw the deceased alive on **4/10/49**, 19____, and that death occurred at **7:15 PM**, from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) John W. Murphy M.D.	23b. ADDRESS 1515 Lafayette Ave.,	23c. DATE SIGNED 4/11/49
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24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE 4/13/49	24c. NAME OF CEMETERY OR CREMATORY Louisville Memorial Park	24d. LOCATION (City, town, or county) (State) Louisville Kentucky
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DATE REC'D BY LOCAL REG. APR 11 1949	REGISTRAR'S SIGNATURE J. B. Casater	25. FUNERAL DIRECTOR'S SIGNATURE Robert J. Carpenter	ADDRESS 6633 Clayton Rd.
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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
Student Embalmer

Signed Ernest W. Spillars

Licensed Embalmer No. 14080

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