No. 300
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THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 14598

BIRTH NO. _____ REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003 Registrar's No. 4036

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

1. PLACE OF DEATH
a. COUNTY
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): ST. LOUIS
c. LENGTH OF STAY (in this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Homer G Phillips Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: MISSOURI
b. COUNTY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): ST. LOUIS 2019
d. STREET ADDRESS (If rural, give location): 4595 GARFIELD AVE.

3. NAME OF DECEASED (Type or Print)
a. (First): Hannah
b. (Middle): —
c. (Last): Pittman

4. DATE OF DEATH (Month) (Day) (Year): April 24 1951

5. SEX: Female 3
6. COLOR OR RACE: COLORED
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): WIDOW 2
8. DATE OF BIRTH: MAR. 28 1907
9. AGE (In years last birthday): 44 — IF UNDER 1 YEAR: Months ✓ Days 20 — IF UNDER 24 HRS.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOUSE WORK
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country): St LOUIS 0
12. CITIZEN OF WHAT COUNTRY?: MO

13a. FATHER'S NAME: JOSEPH WALLACE
13b. MOTHER'S MAIDEN NAME: SARAH BOWENS
14. NAME OF HUSBAND OR WIFE: WALTER PITTMAN

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT'S SIGNATURE OR NAME ADDRESS: Thiel Gaines 4595 GARFIELD AV.

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, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral Thrombosis; Hypertension — INTERVAL BETWEEN ONSET AND DEATH: Undet.

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Hypertension
DUE TO (c) Congestive Failure

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 ☐ NO ☒

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)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR? 332

22. *I hereby certify that I attended the deceased from* 2-6, 1951, *to* 4-24, 1951, *that I last saw the deceased alive on* 4-24, 1951, *and that death occurred at* 4:15p *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): Alvin J Thompson M. D. 0
23b. ADDRESS: 2601 N Whittier St.
23c. DATE SIGNED: 4-25-51

24a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL 0
24b. DATE: 4-30-51
24c. NAME OF CEMETERY OR CREMATORY: GEENWOOD CEM.
24d. LOCATION (City, town, or county) (State): ST. LOUIS CTY. MO

DATE REC'D BY LOCAL REG.: APR 30 1951
REGISTRAR'S SIGNATURE: J B Lasater
25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS: A.F. WALTON 2707 STODDARD ST.

(Licensed Embalmer's Statement on Reverse Side)

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.....

.....

working under my personal supervision.

Student Embalmer No.....

Signed Arthur L. Hilliard

Signed.....
Student Embalmer

Licensed Embalmer No. 4221

P. O. Address 4740 Cupple

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply wit the above constitutes grounds for revocation of license.)

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