

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

FEB 18 1952

BIRTH NO. _____ REG. DIST. NO. 42 PRIMARY REG. DIST. NO. 1000 Registrar's No. 174

1. PLACE OF DEATH a. COUNTY <u>BUCHANAN</u>		2. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission) a. STATE <u>MISSOURI</u> b. COUNTY <u>BUCHANAN</u>	
b. CITY (If outside corporate limits, write RURAL and give township) <u>ST JOSEPH</u>		c. CITY (If outside corporate limits, write RURAL and give township) <u>ST JOSEPH 0117</u>	
c. LENGTH OF STAY (in this place) <u>544</u>		d. STREET ADDRESS (If rural, give location) <u>810 So 10 - St.</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>SISTERS Hosp.</u>			

3. NAME OF DECEASED (Type or Print) a. (First) <u>RAYMOND</u> b. (Middle) <u>BASIN</u> c. (Last) <u>PITTSENBARGER</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>FEB - 13 - 1952</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>MARRIED</u>	8. DATE OF BIRTH <u>APRIL 5 - 1888</u>
9. AGE (in years last birthday) <u>63</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, or if retired) <u>ELEVATOR OPERATOR</u>	11. BIRTHPLACE (State or foreign country) <u>DEARBORN Co. Mo</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, or if retired) <u>ELEVATOR OPERATOR</u>		10b. KIND OF BUSINESS OR INDUSTRY	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13a. FATHER'S NAME <u>STEPHEN PITTSENBARGER</u>		13b. MOTHER'S MAIDEN NAME <u>AMELIA EADS</u>	
13c. NAME OF HUSBAND OR WIFE <u>CECIL PITTSENBARGER</u>		14. NAME OF HUSBAND OR WIFE <u>CECIL PITTSENBARGER</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>1</u>	
17. INFORMANT'S SIGNATURE OR NAME <u>Cecil Pittsenbarger</u>		18. ADDRESS <u>810 So 10 - St. St. Joseph</u>	

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) <u>Bronchiogenic Carcinoma</u>		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. <u>Extreme cachexia</u>		
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION <u>162X</u>		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)	
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?	

22. I hereby certify that I attended the deceased from 1/24, 1952, to 2/13, 1952, that I last saw the deceased alive on 2/13, 1952, and that death occurred at 12:45 P.M., from the causes and on the date stated above.

23a. SIGNATURE <u>Louis P. McCann</u>		23b. ADDRESS <u>1402 Sylvan St. St. Joseph Mo</u>		23c. DATE SIGNED <u>1/13/52</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify)		24b. DATE <u>Feb 13 - 52</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Fairport</u>	
24d. LOCATION (City, town, or county) (State) <u>Fairport Mo</u>		24e. FUNERAL DIRECTOR'S SIGNATURE <u>Charles Russell</u>		24f. ADDRESS <u>Home, Mayfield Mo</u>	
DATE REC'D BY REG. <u>Feb 13, 1952</u>		REGISTRAR'S SIGNATURE <u>Carl C. Casper</u>		5. FUNERAL DIRECTOR'S SIGNATURE <u>Charles Russell</u>	

WRITE PLAINLY—USING 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 ^{will be} was embalmed by me, or by.....

.....
working under my personal supervision.

Student Embalmer No.....

Signed.....
[Handwritten Signature]

Signed.....
Student Embalmer

Licensed Embalmer No. *3960*

P. O. Address *[Handwritten 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.