

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

24269

State File No.

5877

BIRTH NO. _____		REG. DIST. NO. <u>318</u>		PRIMARY REG. DIST. NO. <u>1003</u>		Registrar's No.	
1. PLACE OF DEATH a. COUNTY _____				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>MO.</u> b. COUNTY _____			
b. CITY (If outside corporate limits, write RURAL and give town) <u>ST. LOUIS</u>		c. LENGTH OF STAY (In this place) _____		c. CITY OR TOWN <u>St. Louis</u>		d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>ST. LOUIS CITY HOSPITAL</u>				e. STREET ADDRESS (If rural, give location) <u>6 3117 Norwood Ave</u>			
3. NAME OF DECEASED (Type or Print) a. (First) <u>DELIA</u>		b. (Middle) _____		c. (Last) <u>BITTICKS</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>JUNE 29, 1954</u>	
5. SEX <u>Female</u>		6. COLOR OR RACE <u>W.</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Widowed</u>		8. DATE OF BIRTH <u>July 14, 1884</u>	
9. AGE (In years last birthday) <u>69</u>		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Nursewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>		11. BIRTHPLACE (City and State or Foreign Country) <u>Tennessee</u>	
12. CITIZEN OF WHAT COUNTRY? _____		13a. FATHER'S NAME <u>James Pratt</u>		13b. MOTHER'S MAIDEN NAME <u>Manda Pratt</u>		14. NAME OF HUSBAND OR WIFE <u>Louis</u>	
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 <u>Mrs. Truma Cavolt</u> ADDRESS <u>3117 Norwood</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, asphyxia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Cerebral vascular accident</u> ANTECEDENT CAUSES DUE TO (b) <u>Generalized Arteriosclerosis</u> DUE TO (c) <u>Bronchopneumonia</u> Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.				INTERVAL BETWEEN ONSET AND 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) _____		21d. TIME OF INJURY (Month) (Day) (Year) (Hour) _____	
21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR <u>331X</u>					
22. I hereby certify that I attended the deceased from <u>6-14-54</u> , 19 <u>54</u> , to <u>6-29-54</u> , 19 <u>54</u> , that I last saw the deceased alive on <u>6-29-54</u> , 19 <u>54</u> , and that death occurred at <u>12:15Am.</u> , from the causes and on the date stated above.							
23a. SIGNATURE (Degree or title) <u>Martin G. Austin M.D.</u>				23b. ADDRESS <u>1515 Lafayette Avenue</u>		23c. DATE SIGNED <u>6-29-54</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>removal</u>		24b. DATE <u>6-30-54</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Memorial Park</u>		24d. LOCATION (City, town, or county) (State) <u>St. Louis County MO</u>	
DATE REC'D BY LOCAL REG. <u>JUN 30 1954</u>		REGISTRAR'S SIGNATURE <u>Charles Smith M.D. Drebusman</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Harold</u> ADDRESS <u>1905 Union</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 was embalmed
by me, or by, Student Embalmer No.
working under my personal supervision..

Student.....
Signature of Student Embalmer

Signed *Warren A. Carver*.....

Licensed Embalmer No. *35*.....

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.**