

FILED NOV 16 1954

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

37196

State File No.

BIRTH NO. _____ REG. DIST. NO. 138 PRIMARY REG. DIST. NO. 0023 Registrar's No. 43

1. PLACE OF DEATH		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)	
a. COUNTY <u>Hickory</u>	b. CITY (If outside corporate limits, write RURAL and give township) <u>Pittsburg</u>	c. LENGTH OF STAY (in this place) <u>12 yrs</u>	d. STREET ADDRESS (If rural, give location) <u>0430</u>
3. NAME OF DECEASED (Type or Print)		4. DATE OF DEATH (Month) (Day) (Year)	
a. (First) <u>John</u>	b. (Middle) <u>Sigel</u>	c. (Last) <u>Pitts</u>	<u>11-8-54</u>

5. SEX <u>M</u>	6. COLOR OR RACE <u>W.</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>M.</u>	8. DATE OF BIRTH <u>Aug-14-1876</u>	9. AGE (in years last birthday) <u>78</u>	if UNDER 1 YEAR Months <u>2</u> Days <u>24</u>	if UNDER 24 HRS. Hours <u></u> Min. <u></u>
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FARMER</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>FARMING</u>	11. BIRTHPLACE (State or foreign country) <u>Hickory Co MO</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>
13a. FATHER'S NAME <u>Andrew J Pitts</u>	13b. MOTHER'S MAIDEN NAME <u>Katherine Kirtland Pitts</u>	14. NAME OF HUSBAND OR WIFE <u>Richard Maude Pitts</u>	

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>	16. SOCIAL SECURITY NO. _____	17. INFORMANT'S SIGNATURE OR NAME <u>Maude Pitts</u>	ADDRESS <u>Pittsburg, MO</u>
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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) <u>Cardiovascular renal disease</u>		INTERVAL BETWEEN ONSET AND DEATH <u>1 yr</u>
	ANTECEDENT CAUSES Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>senility</u>		
	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"/>
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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) <u>442X</u>
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? _____

22. I hereby certify that I attended the deceased from 11-1, 1954, to 11-8, 1954, that I last saw the deceased alive on 11-8, 1954, and that death occurred at 3 P m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) <u>C O Bailey</u>	23b. ADDRESS <u>2017 Urbana, Mo</u>	23c. DATE SIGNED <u>Nov 7 1954</u>
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24a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	24b. DATE <u>11-10-54</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Nemo Cemetery</u>	24d. LOCATION (City, town, or county) (State) <u>Hickory Co MO</u>
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DATE REC'D BY LOCAL REG. <u>11-10-54</u>	REGISTRAR'S SIGNATURE <u>Maury Johnson</u>	464- _____	25. FUNERAL DIRECTOR'S SIGNATURE <u>Voyghan Funeral Home Urbana, Mo</u>	ADDRESS _____
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

0430

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 Allen W. Saughan

Licensed Embalmer No. 4156

P. O. Address Urbana, Mo.

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.