

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **42180/66**
Registrar's No. **1212**

FILED JAN 3 1957

BIRTH NO. _____ REG. DIST. NO. **209** PRIMARY REG. DIST. NO. **3043**

1. PLACE OF DEATH a. COUNTY MARION		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE MISSOURI b. COUNTY PIKE	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN HANNIBAL		c. LENGTH OF STAY (in this place) 5 days.	c. CITY OR TOWN FRANKFORD
d. FULL NAME OF HOSPITAL OR INSTITUTION LEVERING HOSPITAL		d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input type="checkbox"/>	
		STREET ADDRESS (If rural, give location) 0827	

3. NAME OF DECEASED (Type or Print)	a. (First) BERNICE	b. (Middle) PITT	c. (Last) TEAGUE	4. DATE OF DEATH (Month) (Day) (Year) DEC. 28-1956
-------------------------------------	---------------------------	-------------------------	-------------------------	---

5. SEX F	6. COLOR OR RACE WHITE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) WIDOWED	8. DATE OF BIRTH SEPT 21-1875	9. AGE (In years last birthday) 81	IF UNDER 1 YEAR Months	IF UNDER 1 YEAR Days	IF UNDER 24 HRS. Hours	IF UNDER 24 HRS. Mins.
-----------------	-------------------------------	---	--------------------------------------	---	------------------------	----------------------	------------------------	------------------------

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and State or Foreign Country) Frankford Mo	12. CITIZEN OF WHAT COUNTRY? U.S.A.
--	-----------------------------------	--	--

13a. FATHER'S NAME James Duncan Pitt	13b. MOTHER'S MAIDEN NAME Natilla Brown	14. NAME OF HUSBAND OR WIFE Robert Teague
---	--	--

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.	17. INFORMANT'S SIGNATURE OR NAME Mervin Teague ADDRESS Wadsworth Kansas
--	-------------------------	--

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, ashenia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral Embolism		5 days
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Artericular Fibrillation		7 days
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 332X	20. AUTOPSY? YES <input type="checkbox"/> NO <input 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 **7-23, 1956** to **12-28, 1956** that I last saw the deceased alive on **12-28, 1956** and that death occurred at _____ m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) Ed A. Kelly, M.D.	23b. ADDRESS Frankford, Mo	23c. DATE SIGNED 12-29-56
---	-----------------------------------	----------------------------------

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE Dec. 30, 1956	24c. NAME OF CEMETERY OR CREMATORY Fairview Cem.	24d. LOCATION (City, town, or county) (State) Frankford Mo
---	--------------------------------	---	---

DATE REC'D BY LOCAL REG. 12-29-56	REGISTRAR'S SIGNATURE Dr. E. M. Lucke	25. FUNERAL DIRECTOR'S SIGNATURE James Negron ADDRESS Frankford Mo
--	--	--

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

RECEIVED JAN 2 1957
MARION HEALTH DEPT.
DATE FILED JAN 2 1957

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 *Joe Fields Meyawa*.....

Licensed Embalmer No. *4093*
P. O. Address *Frankford*

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.