

Health,  
& Welfare  
Public  
Service

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

58-038637

STATE FILE NUMBER

FILED OCT 24 1958

Registration District No. 360 Primary Registration District No. 3076 Registrar's No. 194

S. 300  
1-57

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Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE  
MEDICAL CERTIFICATION

1. PLACE OF DEATH a. COUNTY <b>VERNON</b>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Mo.</b> b. COUNTY <b>Vernon</b>		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>NEVADA MO:</b>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <b>Nevada</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR <b>#411 So. Ash St.</b> INSTITUTION <b>Fanning Rest Home</b>		Length of stay in lb <b>4 yrs</b>	101 <sup>st</sup> STREET ADDRESS		(If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>Merilla</b> Middle <b>Agnes</b> Last <b>Pitts</b>			4. DATE OF DEATH Month <b>Oct.</b> Day <b>16</b> Year <b>1958</b>		
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> & DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Oct 29 1870</b>	9. AGE (In years last birthday) <b>87</b>	FUNDER 1 YEAR Months <b>11</b> Days <b>26</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House Wife</b>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) <b>Richland Co. Mo. 0</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>
13a. FATHER'S NAME <b>Rudolph Forman</b>		13b. MOTHER'S MAIDEN NAME <b>Emaline Moon</b>		14. NAME OF HUSBAND OR WIFE <b>Alvin D. Pitts</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>	17. INFORMANT Address <b>Ralph Pitts Sheldon, Mo</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic Heart Disease, Class IV</b>					INTERVAL BETWEEN ONSET AND DEATH <b>unknown</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____					<b>4200</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not entered in the terminal disease condition in Part I (a) <b>Terminal broncho-pneumonia and cerebral arteriosclerosis, severe.</b>					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> <b>2</b>
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)			
20c. TIME OF INJURY Hour _____ a.m. _____ p.m. _____					
20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION		COUNTY	STATE
21. I attended the deceased from <b>Aug 28, 1956</b> to <b>Oct 16, 1958</b> and last saw her alive on <b>Oct 15, 1958</b> Death occurred at <b>4:30</b> A on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE (Degree or title) <i>James Gascoigne</i>			22b. ADDRESS <b>Moore Building, Nevada, Mo.</b>		22c. DATE SIGNED <b>10-17-58</b>
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town, or county)	(State)
<b>Burial</b>	<b>Oct 17, 1958</b>	<b>Milo Cemetery</b>		<b>Milo Mo</b>	
24. FUNERAL DIRECTOR ADDRESS <b>Beeny Funeral Home Sheldon Mo</b>			25. DATE RECD. BY LOCAL REG. <b>10-17-1958</b>	26. REGISTRAR'S SIGNATURE <i>Anna E. Perry</i>	

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 *H. Bernard Bunn* .....

Licensed Embalmer No. *4161* .....

P. O. Address *Sheldon 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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.

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