

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-036828

FILED VS NOV 9 1959

184 Primary Registration District No. 5692 Registrar's No. 116

STATE FILE NUMBER

INDEXED

1. PLACE OF DEATH a. COUNTY <u>Linn</u> b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Parson Creek Township</u> Length of stay in 1b <u>8 hours</u> c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>am duck blind in duck camp</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Linn</u> c. CITY OR TOWN <u>Brookfield</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> d. STREET ADDRESS <u>206 West Dake</u> (If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
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3. NAME OF DECEASED (Type or print) First <u>Fredus</u> Middle <u>Chester</u> Last <u>Pitcher</u>			4. DATE OF DEATH Month <u>October</u> Day <u>24</u> Year <u>1959</u>			
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>9/26/1888</u>	9. AGE (last birthday) <u>71</u>	IF UNDER 1 YEAR: Months <u>0</u> Days <u>29</u> Hours <u> </u> Min. <u> </u> IF UNDER 24 HR: Hours <u> </u> Min. <u> </u>	

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>R. R. Conductor</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>C. B. & R. R. Co.</u>	11. BIRTHPLACE (City and state or country) <u>Breckenridge Mo.</u>	12. CITIZEN OF WHAT COUNTRY <u>U. S. A.</u>
13a. FATHER'S NAME <u>Chet Pitcher</u>	13b. MOTHER'S MAIDEN NAME <u>Minerva De Vaul</u>	17. NAME OF HUSBAND OR WIFE <u>Fern Pitcher</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>707-07-6431</u>	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH _____
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PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)	PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
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19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	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. Month, Day, Year _____	20d. INJURY OCCURRED WHILE AT WORK <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 _____ to _____ and last saw her/him alive on _____
 Death occurred at approx 11 A.m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) <u>James B. McCallister</u>		22b. ADDRESS <u>Brookfield Mo.</u>		22c. DATE SIGNED <u>Oct 27, 59</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>Oct. 27, 1959</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Rose Hill Cemetery</u>	23d. LOCATION (City, town, or county) (State) <u>Brookfield, Missouri</u>	
24. FUNERAL DIRECTOR ADDRESS <u>Hill Funeral Home, Brookfield, Mo.</u>		25. DATE RECD. BY LOCAL REG. <u>11-2-59</u>	26. REGISTRAR'S SIGNATURE <u>Katharine Johnson</u>	

(Licensed Embalmer's Statement on Reverse Side)

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

3961 6.11. 31

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by _____
or by _____, Student Embalmer No. _____

working under my personal supervision.

Student _____

Signature of Student Embalmer

Signed

Serald I Wade

Licensed Embalmer No. 4172

P. O. Address Brown

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.