

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

Registration District No. **791** Primary Registration District No. **1003**

1. PLACE OF DEATH:
(a) County _____
(b) City or town **St. Louis**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: **St. Luke's**
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **3 Months** (Specify whether years, months or days)
In this community _____ years, months or days

3. (a) PRINT FULL NAME **Ned E. Prindle**
3. (b) If veteran, name war _____ 3. (c) Social Security No. _____
4. Sex **M** 5. Color or race **W**
6. (a) Single, widowed, married, divorced **Married**
6. (b) Name of husband or wife **Juanita Prindle** 6. (c) Age of husband or wife if alive **53** years
7. Birth date of deceased **Jan. 7, 1885**
(Month) (Day) (Year)

8. AGE: Years **55** Months **0** Days **25** If less than one day hr. _____ min. _____

9. Birthplace **Kansas**
(City, town, or county) (State or foreign country)

10. Usual occupation **Farmer**

11. Industry or business _____

MOTHER FATHER
12. Name **E. M. Prindle**
13. Birthplace **Ill.**
(City, town, or county) (State or foreign country)
14. Maiden name **Catherine Bowman**
15. Birthplace **Ill.**
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature **Juanita Prindle**
(b) Address **Whitehall, Ill.**

17. (a) **Burial** (Burial, cremation, or removal) (b) Date thereof **2-2-1940**
(Month) (Day) (Year)

(c) Place: burial or cremation **Whitehall, Ill.**

18. (a) Signature of funeral director **J. B. Waters**
(b) Address **7456 Manchester**

19. (a) **FEB 2 1940** (Date received local registrar) (b) **J. B. Waters** (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State **Illinois** (b) County **Green**
(c) City or town **Whitehall** (If outside city or town limits, write "RURAL") **NR**
(d) Street No. **Rural** (If rural, give location)
(e) If foreign born, how long in U. S. A? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Feb.** day **2** year **1940** hour **4** minute **15 A.** M.
21. I hereby certify that I attended the deceased from **October 11th** 19**39**, to **Feb. 2nd** 19**40**:
that I last saw him alive on **Feb. 1st** 19**40**:
and that death occurred on the date and hour stated above.

Immediate cause of death **Bronchopneumonia, lung abscess, gangrene, gites, osteomyelitis of skull,**
Due to **men. tubercular staphylococcus**
cause of being abscess
Due to **men. pneumonia**
Other conditions: **1070**
(Include pregnancy within 3 months of death)

Major findings:
Of operations **Bronchopneumonia**
Of autopsy **osteomyelitis of skull, gangrene of lung, abscess of lung**
Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify) **No**
(b) Date of occurrence _____
(c) Where did injury occur? **No** (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place?

While at work? **No** (Specify type of place) (e) Means of injury **No**

28. Signature **C. B. Waters** (M. D. or other)
Address **Kirkwood** Date signed **2-2-40**

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.....

....., Registered Apprentice No.....
working under my personal supervision.

Signed.....

J. P. Burgess

Licensed Embalmer No. *4029*

P. O. Address. *Maplewood*

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, above space should be left blank.