

FEB 17 1941

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 3561

Registration District No. 605

Primary Registration District No. 4309

Registrar's No.

1. PLACE OF DEATH:

(a) County New Madrid
(b) City or town Rural
(c) Name of hospital or institution:

(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 5 days

In this community 5 days years, months or days

8. (a) PRINT FULL NAME Hildred Fae Pratt

3. (b) If veteran, name war ✓ (c) Social Security No. ✓

4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced S O

6. (b) Name of husband or wife ✓ 6. (c) Age of husband or wife if alive ✓ years

7. Birth date of deceased January 20 1941 (Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
No No 5 hr. min.

9. Birthplace New Madrid County (City, town, or county) (State or foreign country)

10. Usual occupation ✓

11. Industry or business ✓

12. Name William Pratt

18. Birthplace Missouri (City, town, or county) (State or foreign country)

14. Maiden name Mattie Harris

15. Birthplace N.C. (City, town, or county) (State or foreign country)

16. (a) Informant William Pratt

(b) Address Cothran Mrs Box 131

17. (a) Burial (b) Date thereof Jan 26-41 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Parma Cemetery

18. (a) Signature of funeral director T C Knight

(b) Address Parma Mrs

19. (a) 2-1-41 (b) Dr. Dewhirst (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County New Madrid

(c) City or town Rural (If outside city or town limit, write "RURAL")

(d) Street No. ✓ (If rural, give location)

(e) If foreign born, how long in U. S. A. ✓ 0 years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month January day 25 year 1941 hour 5 minute - P. M.

21. I hereby certify that I attended the deceased from 1-20-41, 19 , to 1-20-41, 19 ;

that I last saw him alive on 1-20-41, 19 ; and that death occurred on the date and hour stated above.

Immediate cause of death Pneumo-pneumonia

Due to.....

Due to.....

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations.....

Of autopsy.....

Duration

PHYSICIAN

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).....

(b) Date of occurrence.....

(c) Where did injury occur? 534 (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place?

While at work? (Specify type of place) (e) Means of injury.....

23. Signature Dr. Dewhirst (M. D. or other) ✓

Address Parma Mrs Date signed 2-5-41

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

2
11-10-39
5-17-39
I X21492

109

RECEIVED

District Health Officer No. 2

District File Number 241-2118

Date Filed 3/11/41

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 _____

Licensed Embalmer No. _____

P. O. Address _____

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.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 3561
Registrar's No.

Registration District No. 605

Primary Registration District No. 4359

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

1. PLACE OF DEATH:

(a) County New Madrid
(b) City or town Como
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether)
In this community _____ (Specify whether)
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State _____ (b) County _____
(c) City or town _____
(If outside city or town limits write "RURAL")
(d) Street No. _____ (If rural, give location)
(e) If foreign born, how long in U. S. A.? _____ years.

3. (a) PRINT FULL NAME Hildred Fae Pratt

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex F 5. Color or race W 6. (a) Single, widowed, married, divorced S

6. (b) Name of husband or wife _____ 6. (c) Age of husband, or wife, if alive _____ years

7. Birth date of deceased. (Month) _____ (Day) _____ (Year) _____

8. AGE: Years _____ Months _____ Days 5 If less than one day _____ min.

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

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER { 12. Name _____

13. Birthplace. (City, town, or county) _____ (State or foreign country) _____

14. Maiden name _____

15. Birthplace. (City, town, or county) _____ (State or foreign country) _____

16. (a) Informant _____

(b) Address _____

17. (a) _____ (b) Date thereof. (Month) _____ (Day) _____ (Year) _____

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) _____ (b) _____ (Date received local registrar) (Registrar's signature)

20. MEDICAL CERTIFICATION

20. DATE OF DEATH. Month Jan day 25 year 1947 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____; that I last saw h. _____ alive on _____, 19____; and that death occurred on the date and hour stated above.

Immediate cause of death Bronch
pneumonia

Due to Influenza

Due to _____

Other conditions (Include pregnancy within 3 months of death) MI

Major findings: Of operations _____

Of autopsy _____

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) _____

(b) Date of occurrence _____

(c) Where did injury occur? _____ (City or town) _____ (County) _____ (State) _____

(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

While at work? _____ (Specify type of place) _____ (e) Means of injury _____

23. Signature A. J. Gilbert (M. D. or other) MD

Address Como Mo Date signed 1-25-47

Duration
1
2
PHYSICIAN
Underline the cause to which death should be charged statistically.

SUPPLEMENTARY

