

No. 2
4-13-40
5-17-39
P1 X23159

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **37278**
4072
Registrar's No.

DEC 22 1941
Registration District No. **399**

Primary Registration District No. **1002**

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

1. PLACE OF DEATH:
(a) County **Jackson**
(b) City or town **Kaw**
(c) Name of hospital or institution:
1812 East 38th. Street
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution
In this community **3 Month 3 weeks** (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State **Missouri** (b) County **Jackson**
(c) City or town **Kansas City**
(If outside city or town limits, write "RURAL")
(d) Street No. **1812 East 38th. Street**
(If rural, give location)
(e) If foreign born, how long in U. S. A.?

3. (a) PRINT FULL NAME **Sarah M. Pritner**
3. (b) If veteran, name war **No**
3. (c) Social Security No. **No**

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month **October** day **29th.**
year **1941** hour **1** minute **P.** M.

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

21. I hereby certify that I attended the deceased from **Oct 27**, 19**41**, to **Oct 29**, 19**41**;
that I last saw her alive on **Oct 28**, 19**41**;
and that death occurred on the date and hour stated above.

6. (b) Name of husband or wife **J. L. Pritner**
6. (c) Age of husband or wife if alive **30** years
7. Birth date of deceased **Aug 30, 1894**
(Month) (Day) (Year)

Immediate cause of death **Lobar Pneumonia**
Duration **1 week**

8. AGE: Years **72** Months **1** Days **29**
If less than one day hr. min.

Due to **Bronchial Asthma**
Due to **1948**

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

Other conditions (Include pregnancy within 3 months of death)

10. Usual occupation **Housework**
11. Industry or business **At Home**

Major findings:
Of operations
Of autopsy
PHYSICIAN
Underline the cause to which death should be charged statistically.

MOTHER FATHER
12. Name **James Patterson**
13. Birthplace **Ohio**
(City, town, or county) (State or foreign country)

14. Maiden name **Harriett Overturf**
15. Birthplace **Ohio**
(City, town, or county) (State or foreign country)

16. (a) Informant **Mr. J. L. Pritner**
(b) Address **5910 Prospect 28th Wenzel**
17. (a) **Burial** (b) Date thereof **11-1-1941**
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation **Elmwood**

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?

18. (a) Signature of funeral director **Mrs. S. L. Forsters**
(b) Address **Kansas City, Mo.**
19. (a) **11-1-41** (b) **M. M. Crow**
(Date received local registrar) (Registrar's signature)

While at work? (Specify type of place) (e) Means of injury
23. Signature **John M. Gowers** (M. D. or other) **MD**
Address **6322 E. 27th St** Date signed **10/30/41**

Dr. John Powers
27th. & Indiana

Lo 1 2 409

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 me

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

Signed

J. C. Sheppard

Licensed Embalmer No. 4179

P. O. Address K. C. 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 this body is not embalmed, fact should be so stated above.