

25466

State File No. _____

Registrar's No. _____

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUSMISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATHRegistration District No. 1120Primary Registration District No. 6300

1. PLACE OF DEATH:

(a) County Shannon
 (b) City or town Rural - Newton Twp
 (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

3. (a) PRINT FULL NAME Francis Lucinda Piatt8. (b) If veteran, name war _____ 8. (c) Social Security No. L

4. Sex F 5. Color or race W
 6. (a) Single, widowed, married, 2 divorced, Widow
 6. (c) Age of husband or wife if alive _____ years
 7. Birth date of deceased April 15 1860
 (Month) (Day) (Year)

8. AGE: Years 82 Months 2 Days 27 If less than one day _____ hr. _____ min.9. Birthplace Dent. Co. MO
(City, town, or county) (State or foreign country)10. Usual occupation House Keeper

11. Industry or business _____

MOTHER FATHER
 12. Name Marion Stewart
 13. Birthplace Kentucky
 14. Maiden name Betty Welsh
 15. Birthplace Dent. Co. MO
 (City, town, or county) (State or foreign country)

16. (a) Informant's own signature Allie Hurt(b) Address Round Spgs. Mo17. (a) Burial (b) Date thereof July 13 1942
(Burial, cremation, or removal) (Month) (Day) (Year)(c) Place: burial or cremation Piatt Cemetery18. (a) Signature of funeral director Hobson & Brantley(b) Address Salem, Mo.19. (a) 7-16-42 (b) Frank Hyde MD
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State MO (b) County Shannon
 (c) City or town Rural - Newton Twp
 (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.? 1 years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 12
year 1942 hour 7 minute 30 P.M.21. I hereby certify that I attended the deceased from 6-1-1942 to July 12 1942
that I last saw her alive on June 14 1942
and that death occurred on the date and hour stated above.Immediate cause of death SepticemiaDue to Fall Injury to Hip
Shin Fract.

Due to _____

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

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 15!

(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 Frank Hyde (M. D. co-signer) _____Address Commercial MO Date signed 7-16-42

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

Rev. 5-17-39

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.

744 (Licensed Embalmer's Statement on Reverse Side)

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 Frank Grable Jr.
Licensed Embalmer No. 4140
P. O. Address Salem, Missouri

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. 25466

Registration District No. 1125

Primary Registration District No. 6882

Registrar's No. _____

1. PLACE OF DEATH:

(a) County Shannon

(b) City or town Rural
(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 _____
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) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME Francis Lucinda Pratt

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July year 1942 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____ 19____
that I or saw him _____ live on _____ 19____
and that death occurred on the date and hour stated above.
Immediate cause of death _____

4. Sex F 5. Color or race W

6. (a) Single, widowed, married, divorced W

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

7. Birth date of deceased April 15 1860
(Month) (Day) (Year)

Due to Deputy

Due to _____

Other conditions Injury to Back & Hip
(Include pregnancy within 3 months of death)

Major findings:
Of operations _____

Of autopsy _____

8. AGE: Years 82 Months 3 Days 2 If less than one day _____ min.

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

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 _____

10. Usual occupation _____

11. Industry or business _____

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)

23. Signature Frank Hyde (M. D. or other) _____
Address Anna Mo Date signed _____

16. (a) Informant _____ (b) Address _____

17. (a) _____ (b) Date thereof _____
(Burial, cremation, or removal) (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)

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

SUPPLEMENTARY

MOTHER FATHER

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

Faint, illegible text on the left side of the page, possibly bleed-through from the reverse side.

Faint, illegible text on the right side of the page, possibly bleed-through from the reverse side.

