

S. No. 2  
9-4-41  
5-17-39  
I X22484

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

15675

State File No. ....

Registrar's No. ....

FILED MAY 7 1943 8  
Registration District No. 8

Primary Registration District No. 4501

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

1. PLACE OF DEATH:

(a) County Stoddard

(b) City or town Bloomfield  
(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) (Specify whether  
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County Stoddard <sup>103</sup>

(c) City or town Bloomfield, <sup>2</sup>  
(If outside city or town limits, write "RURAL") <sup>0</sup>

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

(e) Citizen of foreign country? ..... (Yes or No) <sup>0</sup>  
If yes, name country.....

3. (a) PRINT FULL NAME RUTH JANET PRUITT

3. (b) If veteran, name war ---

3. (c) Social Security No. None

4. Sex Female / race White

5. Color or White

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

6. (b) Name of husband or wife ---

6. (c) Age of husband or wife if alive --- years

7. Birth date of deceased Jan. 14, 1943  
(Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
<u>---</u>	<u>2</u>	<u>22</u>	hr. .... min.

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

10. Usual occupation ---

11. Industry or business ---

MOTHER FATHER { 12. Name James H. Pruitt

13. Birthplace Stoddard co. Mo.  
(City, town, or county) (State or foreign country)

14. Maiden name Lula May Miller

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

16. (a) Informant James F. Miller

(b) Address Bloomfield, Mo.

17. (a) Burial (Burial, cremation, or removal)

(b) Date thereof Apr. 7, 43. (Month) (Day) (Year)

(c) Place: burial or cremation Bluff cemetery

18. (a) Signature of funeral director Chiles Und. Co.

(b) Address Bloomfield, Mo.

19. (a) April 9th/43 (Date received local registrar)

Pearl Coluore (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 6th  
year 1943 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 Lobar Pneumonia Duration

Due to Exposure while moving

Due to ---

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

Major findings: ---  
Of operations ---

Of autopsy ---

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?..... (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 J. A. Chiles Coroner

Address Bloomfield, Mo. Date signed 4-8-43

RECEIVED

District Health Office No. 2,

District File Number 542-625

Date Filed 5-6-42

---

**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 Infant was not embalmed.

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, fact should be so stated above.