

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*

McThorne, Registered Apprentice No. *2876*

working under my personal supervision.

Signed *McThorne*

Licensed Embalmer No. *2876*

P. O. Address *Laclede, Mo*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.

State File No.

Registration District No. 187

Primary Registration District No. 3040

Registrar's No. 107

1. PLACE OF DEATH:
 (a) County Livingston
 (b) City or town Chillicothe
(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 Carrie Lee Pratt
 3. (b) If veteran, name war _____
 3. (c) Social Security No. _____

MEDICAL CERTIFICATION
 20. DATE OF DEATH: Month Sept day _____
 year 1943 hour _____ minute _____ M.
 21. I hereby certify that I attended the deceased from _____ 19____;
 that I last saw him _____ alive 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 Widowed
 6. (c) Age of husband or wife if alive _____ years

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

7. Birth date of deceased: April 13 1862
(Month) (Day) (Year)
 8. AGE: Years 78 Months _____ Days _____
If less than one day _____ min.

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

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 _____
(Burial, cremation, or removal) (Month) (Day) (Year)
 (c) Place: burial or cremation _____

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?

(Specify type of place)
 While at work? _____ (c) Means of injury _____
 23. Signature _____ (M. D. or other) _____
 Address _____ Date signed _____

18. (a) Signature of funeral director _____
 (b) Address _____
 19. (a) _____ (b) Howella Curry
(Date received local registrar) (Registrar's signature)

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

SUPPLEMENTARY

32058