

FILED JAN 10 1944
Registration District No. 274

Primary Registration District No. 3052

1. PLACE OF DEATH: Pettis

(a) County Pettis

(b) City or town Sedalia
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: Bothwell Hospital
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 4 Days
(Specify whether)

In this community _____
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County Pettis

(c) City or town Sedalia
(If outside city or town limits, write "RURAL")

(d) Street No. 512 N Prospect
(If rural, give location)

(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME James Robert Pritchard

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

4. Sex male 5. Color or race white 6. (a) Single, widowed, married, divorced single

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

7. Birth date of deceased July 25 1943
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
		<u>4</u>	<u>15</u>	_____ hr. _____ min.

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

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER { 12. Name Tom Robert Pritchard

{ 13. Birthplace Sedgewick Co. Kansas.
(City, town, or county) (State or foreign country)

{ 14. Maiden name Hazel Maxine Deemmon

{ 15. Birthplace Woodson Co. Kansas.
(City, town, or county) (State or foreign country)

16. (a) Informant Tom Robert Pritchard
(b) Address Sedalia Mo.

17. (a) Funerals (b) Date thereof Dec. 12 1943
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Greenridge Mo.

18. (a) Signature of funeral director McLaughlin Bros.

(b) Address Sedalia Mo.

19. (a) 12/12/43 (b) Mrs Anna Berger
(Data received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec day 10
year 43 hour 2 minute 36 P. M.

21. I hereby certify that I attended the deceased from Dec 8 1943 to Dec 10 1943
that I last saw him alive on Dec 10 1943
and that death occurred on the date and hour stated above.

Immediate cause of death Intussusception Duration 7 days

Due to _____

Due to _____

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

Major findings: Intussusception

Of operation _____

Of autopsy _____

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

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

(b) Date of occurrence _____

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 Mrs Anna Berger (M. D. or other) 2140

Address Sedalia Mo. Date signed 12/14/43

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

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

1022

RECEIVED

District Health Officer No. 8,

District File Number

Date Filed

1-2-44

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 Robert H. Reed

Licensed Embalmer No. 3745

P. O. Address Sedalia 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.

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. Jan.
Registrar's No. _____

Registration District No. _____ Primary Registration District No. _____

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

1. PLACE OF DEATH:

(a) County St. Louis
(b) City or town Sedalia
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Bathnell Hosp.
(If not in hospital or institution, write street number and location)
(d) Length of stay: In hospital or institution 4 da (Specify whether)

In this community _____
years, months or days

3. (a) PRINT FULL NAME James R. Pritchard

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

4. Sex M 5. Color or race W 6. (a) Single, widowed, married, divorced 2

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

7. Birth date of deceased July 25 - 1904
(Month) (Day) (Year)

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

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

10. Usual occupation _____

11. Industry or business _____

MOTHER { 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 _____

18. (a) Signature of funeral director _____

(b) Address _____

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

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 _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec. Day 1 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 _____

Due to Was not due to a congenital condition
Due to _____

Other conditions (include pregnancy within 3 months of death) 122-6-2

Major findings: Same
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 Dr. Beechener (M.D. or other) _____
Address Sedalia Mo Date signed 1/14/44

SUPPLEMENTARY

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

5-43312