S. No. 2
M—2-43
5-17-39
I X35897

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 30038

FILED OCT 4 1945

Registration District No. 9 Primary Registration District No. 4021 Registrar's No.

1. PLACE OF DEATH:

(a) County Audrain.

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

(c) Name of hospital or institution: Laddonia, Missouri! (If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution (Specify whether years, months or days)

In this community 65 Yrs.

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri. (b) County Audrain. 4

(c) City or town Laddonia, Missouri. 0 (If outside city or town limits, write "RURAL")

(d) Street No. 0 (If rural, give location)

(e) Citizen of foreign country? No. 0 (Yes or No)

If yes, name country

3. (a) PRINT FULL NAME Alice F. Prichett.

3. (b) If veteran, name war

3. (c) Social Security No. None.

4. Sex Female 1

5. Color or race White

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

6. (b) Name of husband or wife D.G. Prichett.

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

7. Birth date of deceased May 30, 1852 (Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
93	3	28	hr. min.

9. Birthplace Meiggs County, (City, town, or county) Ohio. 1 (State or foreign country)

10. Usual occupation Housewife.

11. Industry or business Home.

FATHER

12. Name Albert Hoyt.

13. Birthplace Unknown (City, town, or county) Ohio. 1 (State or foreign country)

MOTHER

14. Maiden name Elizabeth Hoyt.

15. Birthplace Unknown (City, town, or county) Ohio. 1 (State or foreign country)

16. (a) Informant Mrs H. W. Snedeker,

(b) Address Laddonia, Missouri.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept. 30, 45 (Month) (Day) (Year)

(c) Place: burial or cremation Laddonia, Missouri.

18. (a) Signature of funeral director Clyde Willey

(b) Address Laddonia, Missouri.

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept. day 28th, year 1945 hour 10:30 minute P. M.

21. I hereby certify that I attended the deceased from Sept 24, 1945, to Sept 28, 1945, that I last saw her alive on Sept 28, 1945, and that death occurred on the date and hour stated above.

Immediate cause of death Lobar Pneumonia — Duration 4 Days

Due to

Due to

Other conditions arterio sclerosis (Include pregnancy within 3 months of death)

Major findings:
Of operations

Of autopsy 106

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? (Specify type of place)

While at work? (e) Means of injury

23. Signature W K McCall (M. D. or other)

Address Laddonia, Missouri Date signed 9-29-45

1535

(Licensed Embalmer's Statement on Reverse Side)

FEB 18 1946

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 Clyde W. Wilke

Licensed Embalmer No. 3820

P. O. Address Perry, Ind.

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.

No. 2B
11—3-45
I X43880

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. Oct

Registration District No. 8 Primary Registration District No. 4021 Registrar's No.

1. PLACE OF DEATH:
(a) County: Audrain
(b) City or town: Laddonia
(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 years, months or days)
In this community

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: Alice F. Prickett
3. (b) If veteran, name war
3. (c) Social Security No.
4. Sex: F
5. Color or race: W
6. (a) Single, widowed, married, divorced: Wid
6. (b) Name of husband or wife
6. (c) Age of husband or wife if alive years
7. Birth date of deceased: May (Month) 30 (Day) (Year)
8. AGE: Years 93 Months Days If less than one day hr. min.
9. Birthplace: (City, town, or county) Ohio (State or foreign country)
10. Usual occupation
11. Industry or business
FATHER 12. Name
13. Birthplace (City, town, or county) (State or foreign country)
MOTHER 14. Maiden name
15. Birthplace (City, town, or county) (State or foreign country)
16. (a) Informant
(b) Address
17. (a) (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)
(c) Place: burial or cremation
18. (a) Signature of funeral director
(b) Address
19. (a) Oct 2nd 45 (Date received local registrar) (b) Martha O'Kennedy (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Day 8 year 1945 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 — Duration
Due to
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? (Specify type of place)
While at work? (e) Means of injury
23. Signature (M. D. or other)
Address Date signed

SUPPLEMENTARY

ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED

FEB 18 1946

30038