

S. No. 2
1-8-43
5-17-39
P I X37823

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

34181

State File No. _____

FILED NOV 3 1945
Registration District No. 206

Primary Registration District No. 5744

Registrar's No. 61

1. PLACE OF DEATH:
(a) County Madison
(b) City or town Cornwall (not in limits)
(c) Name of hospital or institution: 1
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____
In this community 23 years (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Mo. (b) County Madison
(c) City or town Cornwall
(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 James Pritchard
3. (b) If veteran, name war ✓
3. (c) Social Security No. _____

MEDICAL CERTIFICATION
20. DATE OF DEATH, Month Oct. day 15 year 1945 hour 10:20 minute A. M.
21. I hereby certify that I attended the deceased from Oct 14, 1945, to Oct 15, 1945, that I last saw him alive on Oct 15, 1945, and that death occurred on the date and hour stated above.

4. Sex M Color of hair W
5. Color of eyes W
6. (a) Single, widowed, married, divorced married
6. (b) Name of husband or wife Leola J. Pritchard
6. (c) Age of husband or wife if alive 70 years

Immediate cause of death Cerebral hemorrhage Duration 30 hours
Due to acute ~~diffuse~~ glomerulonephritis 1 week
Due to unknown

8. AGE: Years 70 Months 9 Days 3
If less than one day _____ hr. _____ min.

Other conditions (Include pregnancy within 3 months of death) _____
Major findings: Of operations _____
Of autopsy 150

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

10. Usual occupation Coal mining

11. Industry or business _____
12. Name Will Pritchard
13. Birthplace unknown
(City, town, or county) (State or foreign country)
14. Maiden name unknown
15. Birthplace unknown
(City, town, or county) (State or foreign country)

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

16. (a) Informant Leola Pritchard
(b) Address Cornwall, Mo
17. (a) Burial (b) Date thereof Oct. 21-45
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Snoddenville

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? _____

18. (a) Signature of funeral director W. H. Holt
(b) Address Fredricktown, Mo.
19. (a) Oct. 21-45 (b) Flarence Hicks
(Date received local registrar) (Registrar's signature)

While at work? _____ (Specify type of place)
(e) Means of injury 2
23. Signature E. M. DeLaney (M. D. or other) DO.
Address Fredricktown Mo. Date signed 10-16-45

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

RECEIVED

District Health Officer No. 4

District File Number 1145-1248

Date Filed 11-2-45

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 John H. Holt

Licensed Embalmer No. 4264

P. O. Address Federicktown

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.