

S. No. 2  
DM-5-43  
v. 5-17-39  
I X36671

4755

State File No. \_\_\_\_\_

**FILED** FEB 21 1946

Registration District No. \_\_\_\_\_

Primary Registration District No. 5135

Registrar's No. 50

**1. PLACE OF DEATH:**

(a) County Butler

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

(c) Name of hospital or institution:  
Home Ash Hill Twp  
(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 Missouri (b) County Butler / 2

(c) City or town Quilin Rural 0  
(If outside city or town limits, write "RURAL")

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

(e) Citizen of foreign country? no (Yes or No)

If yes, name country \_\_\_\_\_

**3. (a) PRINT FULL NAME** Mont Wade Pratt

3. (b) If veteran, name war \_\_\_\_\_

3. (c) Social Security No. \_\_\_\_\_

**MEDICAL CERTIFICATION**

20. **DATE OF DEATH:** Month January day 21  
year 1946 hour \_\_\_\_\_ minutes 2:30 A.M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_, 19\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_;

4. Sex male 5. Color or race W

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

6. (b) Name of husband or wife Marie Pratt

6. (c) Age of husband or wife if alive 45 years

7. Birth date of deceased Feb. - 28 - 1888  
(Month) (Day) (Year)

that I last saw him \_\_\_\_\_ alive on \_\_\_\_\_, 19\_\_\_\_; and that death occurred on the date and hour stated above.

Immediate cause of death Cardiac Asthma 3 yrs

Due to \_\_\_\_\_

Due to \_\_\_\_\_

**8. AGE:**

Years	Months	Days	If less than one day
<u>57</u>	<u>10</u>	<u>7</u>	hr. _____ min. _____

Other conditions \_\_\_\_\_  
\* (Include pregnancy within 3 months of death)

Major findings:  
Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

9. Birthplace Missouri (State or foreign country)

10. Usual occupation Farming

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? \_\_\_\_\_

**11. Industry or business** \_\_\_\_\_

**12. Name** Edward Pratt

**13. Birthplace** Missouri (State or foreign country)

**14. Maiden name** Maecie Green

**15. Birthplace** Missouri (State or foreign country)

PHYSICIAN \_\_\_\_\_

Underline the cause to which death should be charged statistically.

**16. (a) Informant** Mrs. Marie Pratt

**(b) Address** Quilin, Mo. R. 13

**17. (a) Burial** (Burial, cremation, or removal) Burial (b) Date thereof 1-23-46 (Month) (Day) (Year)

**(c) Place: burial or cremation** Quilin Cemetery

(Specify type of place)

While at work? \_\_\_\_\_ (c) Means of injury \_\_\_\_\_

23. Signature Giora W. Green (Physician)

Address Poplar Bluff Mo Date signed 1-23-46

**18. (a) Signature of funeral director** James Funeral Home

**(b) Address** Campbell, Missouri

**19. (a)** 2/16/46 (Date received local registrar) **(b)** OT Menecke (Registrar's signature)

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

RECEIVED  
District Health Office No. 2,  
District File Number 746-251  
Date Filed 2-20-46

**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 Christina M. Landess  
Licensed Embalmer No. 7227  
P. O. Address Campbell, 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.**