

FILED AUG 19 1946

Registration District No. _____ Primary Registration District No. **3000** Registrar's No. **227**

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

1. PLACE OF DEATH

(a) County **Adair**

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

(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 _____ (Specify whether _____)

In this community _____ years, months or days

3. (a) PRINT FULL NAME **G. A. 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 **Married**

6. (b) Name of husband or wife **Fannie Pritchard** 6. (c) Age of husband or wife if alive **63** years

7. Birth date of deceased **May 18 1880**
(Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
66	2	18	hr. _____ min. _____

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

10. Usual occupation **Farmer**

11. Industry or business _____

MOTHER FATHER

12. Name **Rayston Pritchard**

13. Birthplace **Wassonville**
(City, town, or county) (State or foreign country)

14. Maiden name **Emma Bell**

15. Birthplace **Wassonville**
(City, town, or county) (State or foreign country)

16. (a) Informant **Fannie Pritchard**

(b) Address **Ethel, Mo**

17. (a) **Burial** (b) Date thereof **July 28 1946**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Holt**

18. (a) Signature of funeral director **H. H. McCallum**

(b) Address **South Lufford Mo**

19. (a) **8-5-46** (b) **Kate Lambert**
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Mo** (b) County **Macdon**

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

(d) Street No. **Northwest of Ethel**
(If rural, give location)

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

If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **July** day **26**
year **1946** hour **10** minute **—** A.M.

21. I hereby certify that I attended the deceased from **June 4** 1946 to **July 26** 1946 that I last saw him alive on **July 26** 1946 and that death occurred on the date and hour stated above.

Immediate cause of death **Intestinal fistula** Duration **45 days**

Due to **Abdominal Abscess** **55 days**

Due to **Saddle horn injury - occurred June 4 1946**

Other conditions (Include pregnancy within 3 months of death) **17-50**

Major findings: **Abdominal abscess right iliac fossa**

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) **Fell on saddle horn**

(b) Date of occurrence **June 4 1946**

Where did injury occur? **Ethel Macdon Mo**
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? **on farm**
(Specify type of place)

While at work? **Yes** (e) Means of injury _____

23. Signature **H. H. McCallum M.D.** (M.D. or other) **2**

Address **Wassonville Mo** Date signed **Aug 1 1946**

RECEIVED
District Health Officer No. 19
District File Number 8-46-1549
Date Filed AUG 1 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 J. H. McCallum

Licensed Embalmer No. 2052

P. O. Address South Giffard St

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.