

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

State File No. **34562**

Registration District No. **305** Primary Registration District No. **6047**

Registrar's No. \_\_\_\_\_

1. PLACE OF DEATH:

(a) County St Charles

(b) City or town Forrestell Mo  
(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 \_\_\_\_\_)

In this community Life  
years, months or days

3. (a) PRINT FULL NAME William Luckett Pritchett

3. (b) If veteran, name war L

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

4. Sex MO 5. Color or race W

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

6. (b) Name of husband or wife Laura Pritchett

6. (c) Age of husband or wife if alive 71 years

7. Birth date of deceased Nov 4 1876  
(Month) (Day) (Year)

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

69 11 2 hr. min.

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

10. Usual occupation Retired Farmer

MOTHER FATHER

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

12. Name Wm H Pritchett

13. Birthplace Warren Co Mo  
(City, town, or county) (State or foreign country)

14. Maiden name Jane Luckett

15. Birthplace St Charles Co Mo  
(City, town, or county) (State or foreign country)

16. (a) Informant Laura Pritchett

(b) Address Forrestell Mo

17. (a) Burial (b) Date thereof Oct-8-1946  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Wright City Cem

18. (a) Signature of funeral director Wright City

(b) Address Wright City Mo

19. (a) Oct 7 1946 (b) Mrs Jess Lewis  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County St Charles

(c) City or town Forrestell  
(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 Oct day 6  
year 1946 hour 6 minute \_\_\_\_\_ P.M.

21. I hereby certify that I attended the deceased from Sept 15, 46  
1946 to Oct 5 1946  
that I last saw him alive on Oct 5 1946  
and that death occurred on the date and hour stated above.

Immediate cause of death CORONARY THROMBOSIS

Due to Disease of Coronary Arteries

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

Other conditions Bronchial Asthma  
(Include pregnancy within 3 months of death)

PHYSICIAN

Major findings: \_\_\_\_\_

Of operations AAA

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

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? \_\_\_\_\_

While at work? \_\_\_\_\_ (Specify type of place)

(e) Means of injury 3

23. Signature Raymond P. Hoyer (M.D. or other) \_\_\_\_\_

Address Wright City Mo Date signed 7 Oct 46

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

33383

