

Registration District No. 373

Primary Registration District No. 4544

Registrar's No. _____

1. PLACE OF DEATH:

(a) County Webster
(b) City or town Niangua
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
Schlicht Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 5 days
(Specify whether
In this community 5 days
years, months or days)

3. (a) PRINT FULL NAME JAMES HARRISON PROCK

3. (b) If veteran, name war _____ 3. (c) Social Security No. None

4. Sex M. 5. Color or race W. 6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife Jennie Prock 6. (c) Age of husband or wife if alive 70 years
7. Birth date of deceased: 12 (Month) 14 (Day) 1871 (Year)

8. AGE: Years 75 Months 1 Days 16 If less than one day _____ hr. _____ min.

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

10. Usual occupation Retired farmer

11. Industry or business _____

MOTHER FATHER { 12. Name John F. Prock
13. Birthplace Mo.
(City, town, or county) (State or foreign country)
14. Maiden name Elixabeth Todd
15. Birthplace Mo.
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Jennie Prock
(b) Address Hartville Mo.

17. (a) Burial (b) Date thereof 2 2 47
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Steel Mem. Cem.

18. (a) Signature of funeral director Gene E. Halchen

(b) Address Hartville Mo.

19. (a) 2/17/47 (b) J. McKimney
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County Wright 114
(c) City or town Hartville
(If outside city or town limits, write "RURAL")
(d) Street No. _____
(If rural, give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 1 day 30
year 1947 hour 4:00 minute 30 p. 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
Cerebral Hemorrhage -
apoplexy

Other conditions _____
(Include pregnancy within 3 months of death)

Major findings:
Of operations g. n. a.
Of autopsy _____

Duration

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? _____

While at work? _____ (Specify type of place)
(e) Means of injury _____

23. Signature W. F. Schmitt (M. D. or other) _____
Address St. Louis Mo. Date signed 2/17/47

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

RECEIVED

District Health Officer No. 6;

District File Number 247-260

Date Filed FEB 21 1947

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 Gene E. Holden
Licensed Embalmer No. 3865
P. O. Address Hartsville 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.