S. No. 2
DM—5-43
v. 5-17-39
I X36671

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED SEP 15 1947

Registration District No. 128

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

Primary Registration District No. 2000

Dr. Burke

State File No. 27401

Registrar's No. 727

1. PLACE OF DEATH:

(a) County: GREENE

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

(c) Name of hospital or institution: 1049 W. Harrison
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution: 73 Years (Specify whether years, months or days)
In this community:

2. USUAL RESIDENCE OF DECEASED:

(a) State: Missouri (b) County: Greene 39

(c) City or town: Springfield 2
(If outside city or town limits, write "RURAL")

(d) Street No. 1049 W. Harrison 6
(If rural, give location)

(e) Citizen of foreign country? (Yes or No) 0
If yes, name country:

3. (a) PRINT FULL NAME: Leonard Franklin Prunty

3. (b) If veteran, name war: No

3. (c) Social Security No.: No

4. Sex: Male 0

5. Color or race: White

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

6. (b) Name of husband or wife: Jessie Prunty

6. (c) Age of husband or wife if alive: 65 years

7. Birth date of deceased: Sept. (Month) 11 (Day) 1873 (Year)

8. AGE: Years 73 Months 11 Days 16 If less than one day hr. min.

9. Birthplace: Battlefield (City, town, or county) Missouri (State or foreign country) 0

10. Usual occupation: Retired Farmer

11. Industry or business:

FATHER
12. Name: Daniel Prunty
13. Birthplace: Virginia (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name: Unknown
15. Birthplace: Virginia (City, town, or county) (State or foreign country)

16. (a) Informant: Mrs. Flossie Prunty
(b) Address: Springfield, Mo.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof: 8/19/47 (Month) (Day) (Year)
(c) Place: burial or cremation: Manley Cemetery

18. (a) Signature of funeral director: H.H. Lohmeyer
(b) Address: Springfield, Mo.

19. (a) 8-25-47 (Date received local registrar) (b) W. E. Handley M.D. (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug. day 17 year 1947 hour 3 minute 50p.m.

21. I hereby certify that I attended the deceased from Aug 7, 1947, to Aug 18, 1947; that I last saw him alive on Aug 15, 1947; and that death occurred on the date and hour stated above.

Immediate cause of death: Uremia — Duration

Due to: Strep infection left foot and toes —

Due to:

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

Major findings:
Of operations: 24A

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):

(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? (Specify type of place)

While at work? (e) Means of injury:

23. Signature: W. H. Burke M.D. (M. D. or other)

Address: 410 Woodruff Bldg Date signed: 8/20/47

(Licensed Embalmer's Statement on Reverse Side)

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 Paul L. Lohmeyer

Licensed Embalmer No. 2457

P. O. Address Springfield 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.

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(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 73 Years (Specify whether years, months or days)
In this community

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(a) State: Missouri (b) County: Greene

(c) City or town: Springfield
(If outside city or town limits, write "RURAL")

(d) Street No. 1049 W. Harrison
(If rural, give location)

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

If yes, name country

3. (a) PRINT FULL NAME: Leonard Franklin Prunty

3. (b) If veteran, name war: No

3. (c) Social Security No.: No

4. Sex: Male

5. Color or race: White

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

6. (b) Name of husband or wife: ~~Jessie~~ Jossie Prunty

6. (c) Age of husband or wife if alive: 65 years

7. Birth date of deceased: Sept. (Month) 1 (Day) 1873 (Year)

8. AGE: Years 73 | Months 11 | Days 16 | If less than one day: hr. min.

9. Birthplace: Battlefield (City, town, or county) Missouri (State or foreign country)

10. Usual occupation: Retired Farmer

11. Industry or business:

MOTHER FATHER

12. Name: Daniel Prunty

13. Birthplace: (City, town, or county) Virginia (State or foreign country)

14. Maiden name: Unknown

15. Birthplace: (City, town, or county) Virginia (State or foreign country)

16. (a) Informant: Mrs. ~~Jessie~~ Jossie Prunty

(b) Address: Springfield, Mo.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof: 8/19/47 (Month) (Day) (Year)

(c) Place: burial or cremation: Manley Cemetery

18. (a) Signature of funeral director: H.H. Lohmeyer

(b) Address: Springfield, Mo.

19. (a) 8-25-47 (Date received local registrar) (b) W E Handley MD (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug. day 17 year 1947 hour 3 minute 50p.m.

21. I hereby certify that I attended the deceased from Aug 1, 1947, to Aug 17, 1947, that I last saw him alive on Aug 15, 1947, and that death occurred on the date and hour stated above.

Immediate cause of death: Uremia — Duration

Due to: Strep infection left foot and toes —

Due to:

Items # 7, 6b & 15a corrected by an affidavit from the daughter 2/23/72

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

Major findings:
Of operations:

24A

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):

(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? (Specify type of place)

While at work? (e) Means of injury:

23. Signature: W H Burke M.D. (M. D. or other)

Address: 410 Woodruff Bldg Date signed: 8/22/47

(Licensed Embalmer's Statement on Reverse Side)