

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 20632

2835

BIRTH NO. _____ REG. DIST. NO. 149 PRIMARY REG. DIST. NO. 1000 Registrar's No. _____

1. PLACE OF DEATH a. COUNTY <u>Jackson</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY <u>Jackson</u>	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Kansas City</u>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Kansas City</u>	
c. LENGTH OF STAY (In this place) <u>10 Yrs.</u>			
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>1833 Kensington</u>		d. STREET ADDRESS (If rural, give location) <u>1833 Kensington</u>	

3. NAME OF DECEASED (Type or Print) a. (First) <u>Sallie</u> b. (Middle) <u>Pritchard</u> c. (Last) _____			4. DATE OF DEATH (Month) (Day) (Year) <u>June 20 52</u>		
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5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Widow</u>	8. DATE OF BIRTH <u>Aug. 9th, 1865</u>	9. AGE (In years last birthday) <u>86</u>	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HRS. Hours _____ Mins. _____
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>	11. BIRTHPLACE (State or foreign country) <u>Ind.</u>	12. CITIZEN OF WHAT COUNTRY? <u>U. S.</u>
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13a. FATHER'S NAME <u>Uriah Millikin</u>	13b. MOTHER'S MAIDEN NAME <u>Martha Hensley</u>	14. NAME OF HUSBAND OR WIFE <u>A. P. Pritchard</u>
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u> <u>None</u>	16. SOCIAL SECURITY NO. <u>None</u>	17. INFORMANT'S SIGNATURE OR NAME <u>Miss Iona Pritchard</u>	ADDRESS <u>1833 Kensington</u>
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18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH*(a) <u>Broncho pneumonia</u>		INTERVAL BETWEEN ONSET AND DEATH <u>4 1/2!</u>
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Myocardial degeneration</u>		
	DUE TO (c) <u>Arterio Sclerosis</u>		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			

19a. DATE OF OPERATION _____	19b. MAJOR FINDINGS OF OPERATION _____	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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21a. ACCIDENT SUICIDE HOMICIDE (Specify) _____	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) _____	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) _____
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour) _____	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? _____
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22. I hereby certify that I attended the deceased from June 11, 1952, to June 20, 1952, that I last saw the deceased alive on June 19, 1952, and that death occurred at 7:30 a. m. from the causes and on the date stated above.

23a. SIGNATURE <u>G. C. Remley</u> (Degree or title) <u>MD</u>	23b. ADDRESS <u>852 Argyle Bldg</u>	23c. DATE SIGNED <u>6-21-52</u>
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24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	24b. DATE <u>6/23/52</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Mt. Washington</u>	24d. LOCATION (City, town, & county) (State) <u>Kansas City, Mo.</u>
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DATE REC'D BY LOCAL REG. <u>6-21-52</u>	REGISTRAR'S SIGNATURE <u>Sheraldine Holman</u>	25. FUNERAL DIRECTOR'S SIGNATURE <u>Warp & Sons</u>	ADDRESS <u>Kansas City, Mo.</u>
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

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 _____

Student Embalmer No. _____

working under my personal supervision.

Student
Student Embalmer

Signed _____

Licensed Embalmer No. _____

P. O. Address, _____

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.