

FILED JUN 20 1955

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

20330

State File No.
Registrar's No. 4696

BIRTH NO. _____		REG. DIST. NO. 318		PRIMARY REG. DIST. NO. 1003		Registrar's No. 4696		
1. PLACE OF DEATH a. COUNTY _____				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Iowa b. COUNTY _____				
b. CITY (If outside corporate limits, write RURAL and give OR TOWN St. Louis)		c. LENGTH OF STAY (in this place) _____		c. CITY OR TOWN Washington		d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input type="checkbox"/>		
d. FULL NAME OF HOSPITAL OR INSTITUTION Missouri Baptist Hospital				STREET ADDRESS (If rural, give location) 8178				
3. NAME OF DECEASED (Type or Print) a. (First) RALPH b. (Middle) E c. (Last) PRATT			4. DATE OF DEATH (Month) (Day) (Year) 5 30 55					
5. SEX male		6. COLOR OR RACE white		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED married (Specify)		8. DATE OF BIRTH Feb. 22, 1883		
9. AGE (In years last birthday) 72		IF UNDER 1 YEAR Months _____		IF UNDER 1 YEAR Days _____		IF UNDER 24 HRS. Hours _____ Min. _____		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) operator			10b. KIND OF BUSINESS OR INDUSTRY Motion Picture Theatre Winfield, Iowa			11. BIRTHPLACE (City and State or Foreign Country) / _____		
12. CITIZEN OF WHAT COUNTRY? USA			13a. FATHER'S NAME George Edward Pratt		13b. MOTHER'S MAIDEN NAME Sarah Shockey		14. NAME OF HUSBAND OR WIFE Maude Sample Pratt	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 484-36-1101		17. INFORMANT'S SIGNATURE OR NAME Maude S. Pratt, Washington, Iowa ADDRESS _____				
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) Myocardial Infarction ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Arteriosclerotic heart disease DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Diabetes Mellitus 5 yrs				INTERVAL BETWEEN ONSET AND DEATH 15 days 1 yr.		
19a. DATE OF OPERATION _____		19b. MAJOR FINDINGS OF OPERATION _____				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
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) _____				
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? 4200				
22. I hereby certify that I attended the deceased from 15 MAY, 1955 , to 30 MAY, 1955 , that I last saw the deceased alive on 29 MAY, 1955 , and that death occurred at 9 A. M. , from the causes and on the date stated above.								
23a. SIGNATURE Richard J. Jones MD (Degree or title)				23b. ADDRESS 3720 Washington St. St. Louis, Mo		23c. DATE SIGNED 30 MAY 55		
24a. BURIAL, CREMATION, REMOVAL (Specify) removal		24b. DATE 5-30-55		24c. NAME OF CEMETERY OR CREMATORY Elm Grove Cemetery		24d. LOCATION (City, town, or county) (State) Washington, Iowa		
DATE REC'D BY LOCAL REG. MAY 31 1955		REGISTRAR'S SIGNATURE J. Carl Smith		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS C. R. Lupton & Sons-7233 Delmar Blv'd.,				

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.....
Signature of Student Embalmer

Signed *Clarence H. Mue...*

Licensed Embalmer No. *40...*

P. O. Address *St. Louis*

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.