

Health, Welfare, Public Service
 300
 1-56
 All diseases in Part I must be causally related. Coroner cannot certify to a death due to natural causes. No symptoms will be listed. All standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related. Coroner cannot certify to a death due to natural causes.

THE DIVISION OF HEALTH OF MISSOURI
 STANDARD CERTIFICATE OF DEATH

FILED MAR 6 1957

STATE FILE NUMBER **4536**

Registration District No. 145 Primary Registration District No. 5566 Registrar's No. 119

1. PLACE OF DEATH a. COUNTY <u>Iron</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Iron</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>rural Dent</u> Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		c. CITY OR TOWN <u>Bixby</u> <u>0470</u> Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>X</u>		d. STREET ADDRESS (If outside, give location) <u>X</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) <u>William P Prater</u> <i>First Middle Last</i>			4. DATE OF DEATH <u>Mar 32 1957</u> <i>Month Day Year</i>		
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> <u>3</u>	8. DATE OF BIRTH <u>Jan 1 1876</u>	9. AGE (In years last birthday) <u>81</u>	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Timber</u>	11. BIRTHPLACE (City and state or country) <u>Missouri</u>		12. CITIZEN OF WHAT COUNTRY? <u>U S</u>
13. FATHER'S NAME <u>Dave Prater</u>			14. MOTHER'S MAIDEN NAME <u>Nancy Maxie</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>X</u>	17. INFORMANT Address <u>Roy Lee Prater 2324 McNear St. L</u>		

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u>		INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <u>Mycaroditis</u>	
	DUE TO (c)	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>

20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>4201</u>	
20c. TIME OF INJURY Hour Month, Day, Year a. m. p. m.		
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION COUNTY STATE

21. I attended the deceased from _____ to _____ and last saw her/him alive on _____
 Death occurred at 6:15 P m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <u>W. H. Howell</u> (Degree or title) <u>Coroner 3</u>	22b. ADDRESS <u>Ironton, Mo.</u>	22c. DATE SIGNED <u>3/4/1957</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>	23b. DATE <u>3-5-57</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Upper Indian Cem</u>	23d. LOCATION (City, town, or county) (State) <u>Vibrunem Mo</u>
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24. FUNERAL DIRECTOR <u>Carl R. Jensen</u> ADDRESS <u>Salem Mo</u>	25. DATE RECD. BY LOCAL REG. <u>March 5 - 1957</u>	26. REGISTRAR'S SIGNATURE <u>Mrs Elizabeth Logan</u>
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(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

1129

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.....
Carl H. Jensen

Licensed Embalmer No. *23*

P. O. Address *Salem*

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.