

FRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

=60-002527

FILED VS JAN 25 1960

Registration District No. 209 Primary Registration District No. 3043 Registrar's No. 17 STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY <u>MARION</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MISSOURI</u> b. COUNTY <u>PIKE</u>				
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>HANNIBAL</u>		Length of stay in 1b <u>8 MO.</u>		c. CITY OR TOWN <u>FRANKFORD</u>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>CLARK'S NURSING HOME</u>			Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location)		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>CLAUDE</u> Middle <u>PEW</u> Last <u>PRITCHETT</u>				4. DATE OF DEATH Month <u>JAN</u> Day <u>16</u> Year <u>1960</u>				
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <u>APR 29-1973</u>	9. AGE (last birthday) <u>86</u>	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HR Hours _____ Min. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>SAW-MILL OWNER</u>			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) <u>FRANKFORD MO</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13a. FATHER'S NAME <u>WILLIAM PRITCHETT</u>			13b. MOTHER'S MAIDEN NAME <u>MARTHA JOHNSON</u>			14. NAME OF HUSBAND OR WIFE <u>DAISY PRITCHETT</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO</u>			16. SOCIAL SECURITY NO. <input checked="" type="checkbox"/>		17. INFORMANT Address <u>MRS. ALVA TREAT 2928 GARFIELD HANNIBAL MO.</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>Cerebral thrombosis</u>							INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u>	
DUE TO (b) <u>Generalized Arteriosclerosis</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)							PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
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.)				
20c. TIME OF INJURY Hour _____ a.m. _____ p.m.		Month, Day, Year						
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 <u>7/10/59</u> to <u>1/16/60</u> and last saw her/him alive on <u>1/16/60</u>				Death occurred at _____ on the date stated above, and to the best of my knowledge, from the causes stated.				
22a. SIGNATURE <u>J. Roller, M.D.</u>				22b. ADDRESS <u>Hannibal, Missouri</u>		22c. DATE SIGNED <u>Jan 19/60</u>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE <u>JAN 29-1960</u>	23c. NAME OF CEMETERY OR CREMATORY <u>FAIRVIEW CEMETERY</u>		23d. LOCATION (City, town, or county) <u>FRANKFORD MO</u>				
24. FUNERAL DIRECTOR <u>MEGOWN FUNERAL HOME FRANKFORD MO</u>				25. DATE RECD. BY LOCAL REG. <u>1/19/60</u>		26. REGISTRAR'S SIGNATURE <u>Dr. E. M. Lucke by Lillian M. Herman</u>		

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed Jane Fields Megaw

Licensed Embalmer No. 4093

P. O. Address Frankford

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.