PLACE OF DEATH

County Stone

Township Oto
or
Village ~~Oto~~
or
City _____ (NO. _____, _____ St.; _____ Ward)

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

Registration District No. 1146 File No. 32077

Primary Registration District No. 6284 Registered No. _____

[If death occurred in a hospital or institution, give its NAME instead of street and number]

FULL NAME Jack Milton Pritchard

PERSONAL AND STATISTICAL PARTICULARS

SEX	COLOR OR RACE	SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word)
Male	White	

DATE OF BIRTH November (Month) 11 (Day), 1920 (Year)

AGE 2 yrs. 10 mos. 21 ds. — If LESS than 1 day, ____ hrs. or ____ min.?

OCCUPATION
a) Trade, profession, or particular kind of work _____
b) General nature of industry, business, or establishment in which employed (or employer) _____

BIRTHPLACE (City or town, State or foreign country) _____

NAME OF FATHER William B. Pritchard

BIRTHPLACE OF FATHER (City or town, State or foreign country) Oto Mo

MAIDEN NAME OF MOTHER Fern Carpenter

BIRTHPLACE OF MOTHER (City or town, State or foreign country) Yaxica Mo.

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

Informant) Ettie H. Cox

(ADDRESS) Crane R 2 Mo.

Filed Oct. 3, 1923 H. B. Cox
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH October (Month) 2 (Day), 1923 (Year)

I HEREBY CERTIFY, that I attended deceased from Sept 28, 1923, to Oct 2, 1923, that I last saw him alive on Oct 2, 1923, and that death occurred, on the date stated above, at 7:30 a.m.

The CAUSE OF DEATH* was as follows:

Diphtheria

10 (Duration) ____ yrs. ____ mos. ____ ds.

Contributory (SECONDARY) _____ (Duration) ____ yrs. ____ mos. ____ ds.

(Signed) G. G. Mapler M. D.

Oct 2, 1923 (Address) Clever Mo

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death ____ yrs. ____ mos. ____ ds. In the State ____ yrs. ____ mos. ____ ds.

Where was disease contracted if not at place of death? _____

Former or usual residence _____

PLACE OF BURIAL OR REMOVAL Parsons Cemetery — DATE OF BURIAL Oct 3, 1923

UNDERTAKER W. D. Craig Co. — ADDRESS Galena Mo.

MISSOURI STATE BOARD OF HEALT
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

PLACE OF DEATH

County _____

Township _____ Registration District No. _____ File No. _____

or

Village _____ Primary Registration District No. _____ Registered No. _____

or

City _____ (NO. _____, _____ St.; _____ Ward)

[If death occurred i hospital or institutio give its NAME inste of street and number]

FULL NAME _____

PERSONAL AND STATISTICAL PARTICULARS

SEX	COLOR OR RACE	SINGLE MARRIED WIDOWED OR DIVORCED (*Write* the word)

DATE OF BIRTH _____ (Month) _____ (Day) _____ (Year)

AGE _____ yrs. _____ mos. _____ ds. If LESS than 1 day, ___ hrs. or ___ min.?

OCCUPATION
(a) Trade, profession, or particular kind of work _____

(b) General nature of industry, business, or establishment in which employed (or employer) _____

BIRTHPLACE (City or town, State or foreign country)

PARENTS

NAME OF FATHER _____

BIRTHPLACE OF FATHER (City or town, State or foreign country) _____

MAIDEN NAME OF MOTHER _____

BIRTHPLACE OF MOTHER (City or town, State or foreign country) _____

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) _____

(ADDRESS) _____

Filed _____, 191__, _____

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH _____ (Month) _____ (Day) _____, 191__ (Yea

I HEREBY CERTIFY, that I attended deceased fr _____, 191__, to _____, 191__

that I last saw h _____ alive on _____, 191__

and that death occurred, on the date stated above, at _____

The CAUSE OF DEATH* was as follows:

_____

_____

_____ (Duration) _____ yrs. _____ mos. _____

Contributory (SECONDARY) _____

_____ (Duration) _____ yrs. _____ mos. _____

(Signed) _____ M.

_____, 191__ (Address) _____

*State the Disease Causing Death, or, in deaths from Violent Causes, st (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, RECENT RESIDENTS)

At place of death _____ yrs. _____ mos. _____ ds. In the State _____ yrs. _____ mos. _____

Where was disease contracted if not at place of death? _____

Former or usual residence _____

PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
	_____, 191__
UNDERTAKER	ADDRESS