

MAY 28 1930

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

Do not use this space.

15061

1. PLACE OF DEATH

County Shelby  
Township Franklin  
City Louisiana (No. \_\_\_\_\_)

Registration District No. 830  
Primary Registration District No. 6095

File No. 12  
Registered No. \_\_\_\_\_  
St. \_\_\_\_\_ Ward \_\_\_\_\_

2. FULL NAME Daniel B Pritchard

(a) Residence. No. \_\_\_\_\_ St. \_\_\_\_\_ Ward \_\_\_\_\_  
(Usual place of abode) (If nonresident, give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) married

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Mary E Pritchard

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Nov 1, 1844

7. AGE YEARS MONTHS DAYS If LESS than 1 day, \_\_\_\_\_ hrs. or \_\_\_\_\_ min.  
85 5 6

8. OCCUPATION OF DECEASED  
(a) Trade, profession, or particular kind of work Passer  
(b) General nature of industry, business, or establishment in which employed (or employer) \_\_\_\_\_  
(c) Name of employer \_\_\_\_\_

9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Lewistown Ill

10. NAME OF FATHER Don't know

11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) Don't know

12. MAIDEN NAME OF MOTHER Don't know

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) Don't know

14. INFORMANT D E Pritchard  
(Address) Kansas City Mo

15. FILED May 10 1930 Madge Good REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 5-5 1930

17. I HEREBY CERTIFY, That I attended deceased from 4-5 1930, to 4-7 1930 that I last saw him alive on 4-17 1930, and that death occurred, on the date stated above, at 8 P. m.

THE CAUSE OF DEATH\* WAS AS FOLLOWS: Pneumonia Senile

109A  
CONTRIBUTORY (SECONDARY) 101 B1 (duration) yrs. mos. ds. 3 da.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH \_\_\_\_\_

19. DID AN OPERATION PRECEDE DEATH? no DATE OF \_\_\_\_\_

WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS clinical  
(Signed) A. M. Wood M. D.

5-15 1930 (Address) Shelbia Mo.

\*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) Whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL 100. First Shelbia Mo DATE OF BURIAL May 9 1930

20. UNDERTAKER Hayes ADDRESS Shelbia

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. WRITE PLAINLY. WITH UNFADING INK. THIS IS A PERMANENT RECORD.

