

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.

SEP 24 1930

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

Do not use this space.

26371

1. PLACE OF DEATH

County Spring
Township Wildcat
City..... (No.....) St..... Ward.....

Registration District No. 311
Primary Registration District No. 154 B 2

File No. 26371
Registered No.....
St..... Ward.....

2. FULL NAME Eliza Delila Pratt

(a) Residence. No. 3 St. B Ward. 3
(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 F. 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) widow

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Jan. 23 - 1855

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
75 6 10

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work at Home
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) Jowa
(STATE OR COUNTRY)

10. NAME OF FATHER Wm. B. Anderson

11. BIRTHPLACE OF FATHER (CITY OR TOWN) Ind.
(STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER Ind.

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Ind.
(STATE OR COUNTRY)

14. INFORMANT John L. Pratt
(Address) Springfield, Mo. B. P.

15. FILED 8/9 1930 C. H. Williamson
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Aug 8 1930

17. I HEREBY CERTIFY, That I attended deceased from Aug 1, 1930 to Aug 8, 1930 that I last saw him alive on Aug 1, 1930 and that death occurred, on the date stated above, at 3:10 P.M.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Chronic Nephritis
131
16 1/2 (duration) yrs. mos. ds.

CONTRIBUTORY (SECONDARY) Old age (duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH.....

DID AN OPERATION PRECEDE DEATH?..... DATE OF.....

WAS THERE AN AUTOPSY?.....

WHAT TEST CONFIRMED DIAGNOSIS? Dr. H. Williamson M. D.
(Signed).....

Aug 9, 1930 (Address) Springfield, 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 Funeral Home DATE OF BURIAL 8/9 1930

20. UNDERTAKER Robert T. Phillips ADDRESS Springfield, Mo

Dr. Miller