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.

REC'D MAY 16 1939

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

15104
Do not use this space.

1. PLACE OF DEATH
(a) County Jackson 3 Registration District No. 400
(b) Township or Prairie 1 Primary Registration District No. 5553B. Registered No. 103
(c) City Little Blue (d) Street No. Jackson County Home for the Aged & Infirm
(If death occurred in Hospital or Institution, write its name instead of street and number)
(e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME 630 Samuel B. Prewitt
(a) Residence, No. J C Home St. ☐
(Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: male
4. COLOR OR RACE: white
5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word): Widower
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF: unknown
6. DATE OF BIRTH (MONTH, DAY, AND YEAR): Apr-27-1864
7. AGE: YEARS 74 MONTHS 11 DAYS 27 If LESS than 1 day, ... hrs. or ..... min.

OCCUPATION
8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Labour
9. Industry or business in which work was done, as saw mill, bank, etc.
10. Date deceased last worked at this occupation (month and year)
11. Total time (years) spent in this occupation

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY): Kentucky 1

FATHER
13. NAME: unknown 9
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY): unknown 9

MOTHER
15. MAIDEN NAME: unknown
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY): unknown

17. INFORMANT (ADDRESS): Ernest Jackson To J C Home
18. BURIAL, CREMATION, OR REMOVAL
PLACE Mt Washington DATE Apr 29 1939
19. FUNERAL DIRECTOR (NAME) (ADDRESS): Kettelkin K. C. Mo.
20. FILED 4/29/ 1939 Sara G. Barnes 93 Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR): apr 24, 1939
22. I HEREBY CERTIFY, That I attended deceased from 4-1, 1939, to 4-24, 1939
I last saw him alive on 4-22, 1939 Death is said to have occurred on the date stated above, at 6a m.
The principal cause of death and related causes of importance were as follows:
chronic myocarditis
Date of onset
92 C
Other contributory causes of importance:
Name of operation Clinical Date of
What test confirmed diagnosis Was there an autopsy? no
23. If death was due to external causes (violence), fill in also the following:
Accident, suicide, or homicide? Date of injury, 19
Where did injury occur? (Specify city or town, county, and State)
Specify whether injury occurred in industry, in home, or in public place.
Manner of injury
Nature of injury
24. Was disease or injury in any way related to occupation of deceased? no
If so, specify
(Signed) J W Greene, M. D.
(Address) Independence Mo

(Licensed Embalmer's Statement on Reverse Side)

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.....

....., Registered Apprentice No.....

working under my personal supervision.

Signed.....

Licensed Embalmer No.....

P. O. Address.....

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to com with the above constitutes grounds for revocation of license.)

If this body is not embalmed, above space should be left blank.