

WRITE PLAINLY, WITH UNFADING INK---THIS IS A PERMANENT RECORD

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.

1939 SEP 23 1939

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

33001
Do not use this space.

1. PLACE OF DEATH

(a) County Mississippi Registration District No. 566
(b) Township Tywapatty Primary Registration District No. 3030
(c) City Charleston (d) Street No. _____ St.
(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.

Registered No. 972. PRINT FULL NAME Mollie Pruitt

(a) Residence, No. Charleston, Mo. St. (If nonresident, give city or town and State)
(Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE Colored 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Widowed

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

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

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, _____ hrs. or _____ min.
About 75

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc.
9. Industry or business in which work was done, as saw mill, bank, etc. Retired housewife
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) Mississippi

13. NAME Not known

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) _____

15. MAIDEN NAME Not known

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) _____

17. INFORMANT Valree Pruitt
(ADDRESS) 432 Ottawa St. Muskegan, Mich

18. BURIAL, CREMATION, OR REMOVAL PLACE Columbus, Kentucky 9/26, 39

19. FUNERAL DIRECTOR (NAME) (ADDRESS) Lair-Nunnelee
Charleston, Mo

20. FILED 9-26-39 F D Verum
Local Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 9-21-1939

22. I HEREBY CERTIFY, That I attended deceased from 9-14-1939 to 9-20-1939

I last saw her alive on 9-20-1939. Death is said to have occurred on the date stated above, at 5:30 p.m.

The principal cause of death and related causes of importance were as follows:

Coronary Occlusion

Date of onset

Other contributory causes of importance: 94 h

Name of operation none 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? _____
If so, specify _____
(Signed) W. A. Lingal M. P.
(Address) 311 S. 8th St. Charleston Mo.

RECEIVED

District Health Officer No. 2,

District File Number 1039-220

Date Filed 10-3

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 John P. Funnelle Jr

Licensed Embalmer No. 3851

P. O. Address Charleston Mo.

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