

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. PHYSICIANS should state N. E.—Every item of information should be carefully supplied. AGE should be stated EXACTLY.

1939 OCT 13 1939  
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MISSOURI STATE BOARD OF HEALTH  
 BUREAU OF VITAL STATISTICS  
 CERTIFICATE OF DEATH

33693  
 Do not use this space.

1. PLACE OF DEATH  
 (a) County Stoddard Registration District No. 836  
 (b) Township 2 Primary Registration District No. 6100 Registered No. 86  
 (c) City R.F.D. Parma (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. 11 mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME HENRY ELLIS PRUETT  
 (a) Residence, No. Stoddard Co. 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

MEDICAL CERTIFICATE OF DEATH

3. SEX M 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED Single  
 5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF \_\_\_\_\_  
 6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Aug. 21, 1938  
 7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.  
X 10 19  
 OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. infant  
 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) R.F.D. Parma Mo.  
 FATHER 13. NAME William E. Pruett  
 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Stoddard Co. Mo.  
 MOTHER 15. MAIDEN NAME Rosa B. Walker  
 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Stoddard Co Mo.  
 17. INFORMANT (ADDRESS) William E. Pruett  
Parma Mo.  
 18. BURIAL, CREMATION, OR REMOVAL PLACE Dayle Hill DATE July 15, 1939  
 19. FUNERAL DIRECTOR (NAME) (ADDRESS) Hopkin Funeral Home  
Berwick Mo.  
 20. FILED Sept 26, 1939 Laura Hopkins  
Local Registrar.

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 7-14-1939  
 22. I HEREBY CERTIFY, That I attended deceased from 7-14- 1939, to 7-14- 1939  
 I last saw him alive on 7-14- 1939 Death is said to have occurred on the date stated above, at 6 P.M.  
 The principal cause of death and related causes of importance were as follows:  
Politis  
1196  
 Date of onset \_\_\_\_\_  
 Other contributory causes of importance: \_\_\_\_\_  
 Name of operation \_\_\_\_\_ Date of \_\_\_\_\_  
 What test confirmed diagnosis? \_\_\_\_\_ Was there an autopsy? \_\_\_\_\_  
 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) Dawsey Ryan, M. D.  
 Address Berwick Mo.

**RECEIVED**

District Health Officer No. 2

District File Number 1039-252

Date Filed 10-9

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**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 comply with the above constitutes grounds for revocation of license.)**

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