

FILED MAR 12 1940

STANDARD CERTIFICATE OF DEATH

State File No.

6648

Registration District No. 318

Primary Registration District No. 2001

Registrar's No.

173

1. PLACE OF DEATH:

(a) County Greene
(b) City or town Springfield
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: St. John Hosp.
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 7 hrs.
(Specify whether
In this community _____
years, months or days)

8. (a) PRINT FULL NAME Ernestine Mackey Prichard

8. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced MARRIED

6. (b) Name of husband or wife (unk.) Prichard 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased Sept. 16 1904
(Month) (Day) (Year)

8. AGE: Years 7 35 Months 5 Days 1 If less than one day hr. _____ min. _____

9. Birthplace Willow Springs Missouri
(City, town, or county) (State or foreign country)

10. Usual occupation Secretary

11. Industry or business _____

MOTHER FATHER { 12. Name Michael Mackey
18. Birthplace Galesburg, Ill.
(City, town, or county) (State or foreign country)
14. Maiden name Ruth Cooper
15. Birthplace Marshfield Missouri
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Chas L. Johnson
(b) Address Springfield, Mo.

17. (a) Burial (b) Date thereof Feb. 19 1940
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation St. Mary's Cem.

18. (a) Signature of funeral director H. H. Lohmeyer
(b) Address Springfield, Mo.

19. (a) 2/19/40 (b) Chas. A. George
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Greene
(c) City or town Springfield
(If outside city or town limits write "RURAL")
(d) Street No. 1224 E. Elm
(If rural, give location)
(e) If foreign born, how long in U. S. A. _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb. day 17
year 1940 hour 4 minute P. M.

21. I hereby certify that I attended the deceased from 2-16
1940 to 2-17 1940
that I last saw her alive on 2-17 1940
and that death occurred on the date and hour stated above.

Immediate cause of death Acute Nephritis Duration 6 weeks

Due to Streptococcus
infectum

Due to _____
Other conditions. (Include pregnancy within 3 months of death) _____

Major findings: Of operations _____
Of autopsy _____
PHYSICIAN _____
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify) _____
(b) Date of occurrence _____
(c) Where did injury occur? _____ (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

While at work? _____ (Specify type of place) (e) Means of injury _____
Signature Chas. A. George (M. D. or other) _____
Address Springfield Mo Date signed 2-20-40

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

12 D

ORIGINAL RECORD

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 *L. Decker Gorman*

Licensed Embalmer No. *3177*

P. O. Address *Springfield 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.

X

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 6648
Registrar's No. 173

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

Registration District No. 318 Primary Registration District No. 2001

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH:
(a) County Greene
(b) City or town Springfield
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution.....
In this community..... (Specify whether years, months or days)

3. (a) PRIN Ernestine Mackey Prichard
FULL NAME
3. (b) If veteran, name war..... 3. (c) Social Security No.....

4. Sex 7 5. Color or race W 6. (a) Single, widowed, married, divorced m
6. (b) Name of husband or wife..... 6. (c) Age of husband, or wife, if alive..... year.....
7. Birth date of deceased..... (Month) (Day) (Year)

8. AGE: Years 35 Months 5 Days 1 If less than one day..... min.

9. Birthplace..... (City, town, or county) (State or foreign country)

10. Usual occupation.....

11. Industry or business.....

MOTHER FATHER { 12. Name.....

{ 13. Birthplace..... (City, town, or county) (State or foreign country)

{ 14. Maiden name..... (City, town, or county) (State or foreign country)

{ 15. Birthplace..... (City, town, or county) (State or foreign country)

16. (a) Informant.....

(b) Address.....

17. (a)..... (b) Date thereof..... (Month) (Day) (Year)

(c) Place: burial or cremation.....

18. (a) Signature of funeral director.....

(b) Address.....

19. (a)..... (b)..... (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State..... (b) County.....
(c) City or town..... (If outside city or town limits write "RURAL")
(d) Street No..... (If rural, give location)
(e) If foreign born, how long in U. S. A.?..... years

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month Feb day 17 year 1940 hour..... minute..... M.
21. I hereby certify that I attended the deceased from..... 19..... to..... 19..... that last saw h..... alive on..... 19..... and that death occurred on the date and hour stated above.

Immediate cause of death acute nephritis
Due to Streptococcus ab
Infection
Due to cause stated above (Strep) Nephritis
Other conditions (Include pregnancy, within 3 months of death) Did not follow
Major findings: Chronic nephritis
Of operations.....
Of autopsy.....

Duration
PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify).....
(b) Date of occurrence.....
(c) Where did injury occur?..... (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place?.....

While at work?..... (Specify type of place) (e) Means of injury.....

23. Signature Robt M Vineyard (Physician, or other)
Address Springfield Mo

SUPPLEMENTAL

