

N. B.—WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD. 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. See instruction on back of certificate.

FILED MAR 21 1940

ARKANSAS STATE BOARD OF HEALTH  
Bureau of Vital Statistics  
CERTIFICATE OF DEATH

Do Not Use This Space

7254

1. PLACE OF DEATH \_\_\_\_\_  
 Registration District No. 963  
 Township Elk River ✓  
 Primary Registration District No. 3-692 File No. 204-76  
 Inc. Town or City Wash (No. \_\_\_\_\_ St. \_\_\_\_\_ Ward \_\_\_\_\_)  
 (If death occurred in a hospital or institution, give its NAME instead of street and number)  
 Length of residence in city or town where death occurred \_\_\_\_\_ yrs., \_\_\_\_\_ mos., \_\_\_\_\_ days. How long in U. S., if of foreign birth? \_\_\_\_\_ yrs., \_\_\_\_\_ mos., \_\_\_\_\_ days.

2. FULL NAME Sarah May Pritchard  
 (a) Resident: No. Paul of mo. St. \_\_\_\_\_ Ward \_\_\_\_\_  
 (Usual place of abode) (If non-resident, give city or town and state)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX F 4. COLOR OR RACE White 5. Single, Married, Widowed or Divorced (write the word) Widowed  
 6a. If married, widowed, or divorced, HUSBAND of (or) WIFE of J. F. Pritchard  
 6. DATE OF BIRTH Mar - 17 - 1859  
 (Month) (Day) (Year)  
 7. AGE Years 80 Months 9 Days 28 If LESS than 1 day \_\_\_\_\_ hrs. or \_\_\_\_\_ min.  
 OCCUPATION 8. Trade, profession, or particular kind of work done, as spinner sawyer, bookkeeper, etc. Housewife  
 9. Industry or business in which work was done, as silk mill, saw mill, bank, etc. \_\_\_\_\_  
 10. Date deceased last worked at this occupation (month and year) \_\_\_\_\_ 11. Total time (years spent in this occupation) 65 yrs

12. BIRTHPLACE (city or town) (State or Country) Texas

PARENTS  
 13. NAME OF FATHER Jacob Harris  
 14. BIRTHPLACE OF FATHER (City or Town) (State or Country) England  
 15. MAIDEN NAME OF MOTHER Mary Jane Bensch  
 16. BIRTHPLACE OF MOTHER (City or Town) (State or Country) New York

17. INFORMANT (Address) Mrs. Mary Louless

18. BURIAL, CREMATION OR REMOVAL Place \_\_\_\_\_ Date \_\_\_\_\_ 19 \_\_\_\_\_

19. Undertaker (Address) Peace Funeral Home  
465

20. Filed 2-10 1940 C. Alexander

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH Tues Jan 15 - 1940  
 (Month, Day, Year)  
 22. I HEREBY CERTIFY, That I attended deceased from \_\_\_\_\_, 1938, to Jan 15 - 1940  
 I last saw her alive on Jan 14 - 1940; death is said to have occurred on the date stated above at 5:30 A.m.  
 The principal cause of death, and related causes of importance, were as follows: \_\_\_\_\_  
 Date of onset \_\_\_\_\_

Other Contributory causes of importance:  
Angina Pectoris  
Calcium of Uterus & Bladder

Name of operation none 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? L Date of injury L, 19L  
 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) E. P. [Signature] M. D.  
 Address Sulphur Springs Ark.

# ARKANSAS STANDARD CERTIFICATE OF DEATH

**Statement of Occupation.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the deceased had retired from business, report the occupation prior to retirement. Children not gainfully employed may be returned as *at school* or *at home*. For a woman whose only occupation was that of home housework, write *housewife* in answer to Question 8 and *own home* in answer to Question 9. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate term, as *servant—private family, cook—hotel, etc.* For a person who had no occupation whatever, write *none*.

To be complete, an occupation return must state:

8. The trade, profession, or particular kind of work done.
9. The industry or business in which the work was done.
10. The month and year the deceased last worked at the occupation.
11. The number of years the deceased followed the occupation.

In stating the occupation avoid the use of such indefinite terms as "employee," "worker," "operative," etc. Find out the particular kind of work done and return that, as *spinner, weaver, etc.*

In stating the industry or business, avoid the use of such general terms as "store," "factory" "mill," etc. State the particular kind of store, factory, mill, etc., as *grocery store, soap factory, cotton mill, etc.*

Distinguish carefully the different kinds of engineers by stating the full descriptive titles, as *civil engineer, mechanical engineer, mining engineer, stationary engineer, etc.* Avoid the term "laborer" when a more precise statement of the occupation can be secured. Do not use the word "mechanic," but give the exact occupation, as *carpenter, painter, machinist, etc.* Distinguish carefully between *retail merchants* and *wholesale merchants*. A person who sells goods should be called a *salesman* and not a *clerk*.

**Statement of Cause of Death.**—Cause of death means the disease, injury, or complication which causes death, *not* the mode of dying, e. g., heart failure, asphyxia, asthma, etc. As principal cause name the disease or injury causing death. As related causes name earlier morbid conditions, if any, related to the principal cause and any important complication of the principal cause. Under other contributory causes of importance, name other important diseases or injuries. Examples:

EXAMPLE I	Date of Onset	EXAMPLE II	Date of Onset
The principal cause of death and related causes of importance were as follows:		The principal cause of death and related causes of importance were as follows:	
<i>Arteriosclerosis</i>	1915	<i>Attack of epilepsy</i>	1 week ago
<i>Chronic interstitial nephritis</i>	1921	<i>Run over by street car</i>	1 week ago
<i>Cerebral hemorrhage</i>	July 5, 1927	<i>Peritonitis</i>	3 days ago
Other contributory causes of importance:		Other contributory causes of importance:	
<i>Gall stones</i>	May 1, 1923	<i>Gastroenteritis</i>	1 year

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN

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MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. 7254  
Registrar's No. ....

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

Registration District No. 963

Primary Registration District No. 3692

1. PLACE OF DEATH:

(a) County Madison  
(b) City or town Ell River Rural  
(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.....  
(Specify whether  
In this community.....  
years, months or days)

3. (a) PRIN FULL Sarah May Pritchard

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 wid

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 Months Days If less than one day  
80 9 28 hr. min.

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

10. Usual occupation.....

11. Industry or business.....

12. Name.....

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

14. Maiden name.....

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 1 day 15 year 1948 hour..... minute..... M.

21. I hereby certify that I attended the deceased from....., 19....., to....., 19.....; that I last saw him..... alive on....., 19....., and that death occurred on the date and hour stated above.

Immediate cause of death Senility Duration

Due to Arteriosclerosis of the uterus

Due to as primary dated 1-20-48

Other conditions..... (Include pregnancy within 3 months of death) 48

Major findings: Angina Pectoris  
Of operation: Carcinoma of uterus  
+ bladder

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.....

23. Signature G. B. Skagg (M. D. or other).....

Address Sulphur Springs Date signed act

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

SUPPLEMENTAL

S-7254