

MAY 13 1940

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

Do not use this space.

16292

1. PLACE OF DEATH  
County Stoddard Registration District No. 838  
Township Liberty Primary Registration District No. 4509  
City Dexter Mo (No. 630) St. \_\_\_\_\_ Ward \_\_\_\_\_

File No. \_\_\_\_\_  
Registered No. \_\_\_\_\_  
St. \_\_\_\_\_ Ward \_\_\_\_\_

2. FULL NAME Sarah Elizabeth Pruitt  
(a) Residence, No. \_\_\_\_\_ St. \_\_\_\_\_ Ward \_\_\_\_\_  
(Usual place of abode) (If nonresident, give city or town and State)  
Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) married  
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Dec-8-1865  
7. AGE YEARS 74 MONTHS 3 DAYS 21 If LESS than 1 day, hrs. or min.

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 3-31-10 AM 1940  
22. I HEREBY CERTIFY, That I attended deceased from 3-28-, 1940, to 3-31-, 1940  
I last saw him alive on 3-29-, 1940 Death is said to have occurred on the date stated above, at 10 A m.

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc.  
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.

The principal cause of death and related causes of importance were as follows:  
Cardiac failure from a chronic suprachorditis.

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Rice Co Ind.  
13. NAME John Faith  
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Rice Co Ind.  
15. MAIDEN NAME Sophronie James  
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Rice Co Ind.

Other contributory causes of importance:  
Chronic pulmonary tuberculosis

17. INFORMANT (ADDRESS) C N Pruitt  
18. BURIAL, CREMATION, OR REMOVAL PLACE Nagy DATE April 1, 1940  
19. UNDERTAKER (ADDRESS) Eda Baird  
20. FILED 5/6 1940 Jennie Benton Registrar.

Name of operation \_\_\_\_\_ Date of \_\_\_\_\_  
What test confirmed diagnosis? Clinical 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) Frank Parker, M. D.  
755 (Address) Dexter Mo.

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.

RECORD 3

RECEIVED

District Health Officer No. 2

District File Number 540-7031

Date Filed 5/10/40

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. 16292

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

Registration District No. 838

Primary Registration District No. 4509

Registrar's No. \_\_\_\_\_

1. PLACE OF DEATH

(a) County Stoddard  
(b) City or town Chester  
(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)

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.

3. (a) PRINT FULL NAME

Sarah Elizabeth Pruitt

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 74 Months 3 Days 21  
If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

9. Birthplace \_\_\_\_\_

(City, town, or county) (State or foreign country)

10. Usual occupation Housewife

11. Industry or business old age pensioner

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 \_\_\_\_\_

(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation \_\_\_\_\_

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

(b) Address \_\_\_\_\_

19. (a) 5-6-40

(Date received local registrar)

(b) Frank LaRue, Reg.

(Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 3 day 31  
year \_\_\_\_\_ hour \_\_\_\_\_ minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_, 19\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_;  
that I last saw h. \_\_\_\_\_ alive on \_\_\_\_\_, 19\_\_\_\_;  
and that death occurred on the date and hour stated above.  
Immediate cause of death \_\_\_\_\_

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions \_\_\_\_\_  
(include pregnancy within 3 months of death)

Major findings: \_\_\_\_\_

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)  
Means of injury \_\_\_\_\_

23. Signature Frank LaRue (M. D. or other) \_\_\_\_\_

Address Chester Mo Date signed \_\_\_\_\_

SUPPLEMENTAL

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

