

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. **29820**

Dr. Anderson

Registration District No. **819**

Primary Registration District No. **6068**

Registrar's No.

1. PLACE OF DEATH:

(a) County **Scott**  
(b) City or town **Rfd, # 1 Morley, Mo**  
(c) Name of hospital or institution:  
(If not in hospital or institution, write street number or location) **2**  
(d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether \_\_\_\_\_)  
In this community **2 Months** (years, months or days)

3. (a) PRINT FULL NAME **Frances E. Pratt** **630**

3. (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 **Albert Pratt** 6. (c) Age of husband or wife if alive **68** years

7. Birth date of deceased **Aug 28 1887**  
(Month) (Day) (Year)

8. AGE: Years **52** Months **10** Days **15** If less than one day hr. min.

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

10. Usual occupation **Domestic**

11. Industry or business \_\_\_\_\_

12. Name **Jeff McDonald**

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

14. Maiden name **Unknown**

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

16. (a) Informant's own signature **Edmore Pratt**

(b) Address **Sikeston, Mo, Rfd, # 3**

17. (a) **Burial** (b) Date thereof **7/14/40**  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **McMullin, Mo**

18. (a) Signature of funeral director **John McMullin**

(b) Address **Sikeston, Mo**

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

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **Scott**  
(c) City or town **Morley**  
(If outside city or town limits, write "RURAL")  
(d) Street No. **Rfd, # 1**  
(If rural, give location)  
(e) If foreign born, how long in U. S. A.? \_\_\_\_\_ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **July** day **13th**,  
year **1940** hour **1:00** minute **40** P. M.

21. I hereby certify that I attended the deceased from **July 8, 1940** to **July 13, 1940**  
that I last saw **alive on July 11, 1940**  
and that death occurred on the date and hour stated above.

Immediate cause of death **Cerebral hemorrhage**  
Due to **hypertension**  
Due to \_\_\_\_\_  
Other conditions (include pregnancy within 3 months of death) **None**

Major findings: Of operations **None**  
Of autopsy **None**

22. If death was due to external causes, fill in the following:  
(a) Accident, suicide, or homicide (specify) **None**  
(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?  
(Specify type of place) **White at work** (e) Means of injury \_\_\_\_\_

23. Signature **Dr. Anderson** (M. D. or other) \_\_\_\_\_  
Address **Sikeston** Date signed **8-19-40**

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

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

RECEIVED  
District Health Officer No. 2,  
District File Number 940 - 144  
Date Filed 9/10/40

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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.....

was not embalmed Registered Apprentice No.....  
working under my personal supervision.

Signed John A. [Signature]  
Licensed Embalmer No. 7941  
P. O. Address [Signature]

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.

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. **298 20**

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

Registration District No. **819**

Primary Registration District No. **6068**

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

1. PLACE OF DEATH

(a) County **Scott**  
(b) City or town **Merley T.P.**  
(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)

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

**Frances E. Pratt**

3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

4. Sex **of** 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 \_\_\_\_\_ years

7. Birth date of deceased (Month) (Day) (Year)

8. AGE: Years Months Days If less than one day  
**52 10 15** 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) (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)

(c) Place: burial or cremation

18. (a) Signature of funeral director

(b) Address

19. (a) **Oct 17 - 1940** (b) **Mrs. D. Daugherty**  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION  
20. DATE OF DEATH Month **7** day **13**  
year \_\_\_\_\_ 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 \_\_\_\_\_

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

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

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

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 \_\_\_\_\_ (M. D. or other)

Address \_\_\_\_\_ Date signed \_\_\_\_\_

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

SUPPLEMENTARY

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

