

Registration District No. **224**

Primary Registration District No. **5300**

Registrar's No. **12**

1. PLACE OF DEATH:  
(a) County **Copper**  
(b) City or town **Prairie Home 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 **2**

3. (a) PRINT FULL NAME **ELOE FRANKLIN PINDEXTER**  
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 **Widowed**  
6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_ years  
7. Birth date of deceased **Sept 20 1867**  
(Month) (Day) (Year)

8. AGE: Years **73** Months **1** Days **17** If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

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

10. Usual occupation **Housewife**

11. Industry or business \_\_\_\_\_  
12. Name **C. O. Franklin** 1  
13. Birthplace **Tennessee** (City, town, or county) (State or foreign country)  
14. Maiden name **Elizabeth Spurlock** 1  
15. Birthplace **Kentucky** (City, town, or county) (State or foreign country)

16. (a) Informant's own signature **Mrs. H. K. Hilbreath**  
(b) Address **Prairie Home MO**  
17. (a) **Burial** (b) Date thereof **11-9-1940**  
(Burial, cremation, or removal) (Month) (Day) (Year)  
(c) Place: burial or cremation **Walnut Grove, Cema.**

18. (a) Signature of funeral director **C. Albert Hombeck**  
(b) Address **Prairie Home MO**  
19. (a) \_\_\_\_\_ (b) \_\_\_\_\_  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:  
(a) State **MO** (b) County **Copper**  
(c) City or town **Rural** (If outside city or town limits, write "RURAL")  
(d) Street No. \_\_\_\_\_ (If rural, give location) **0**  
(e) If foreign born, how long in U. S. A.? **All life** years.

MEDICAL CERTIFICATION  
20. DATE OF DEATH: Month **Nov** day **6**  
year **1940** hour **5** minutes **9** M.  
21. I hereby certify that I attended the deceased from **June 30**, 19**40** to **Nov 6**, 19**40**  
that I last saw him alive on **Nov 4**, 19**40**  
and that death occurred on the date and hour stated above.

Immediate cause of death **Carcinoma uterus**

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? **202**  
While at work \_\_\_\_\_ (Specify type of place) (e) Means of injury \_\_\_\_\_  
23. Signature **A. K. Meredith** (M. D. or other) **real**  
Address **Prairie Home MO** Date signed **11-7-40**

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 state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

---

---

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 C. Albert Hornbeck

Licensed Embalmer No. 2714

P. O. Address Prairie Home, 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.**

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. 385-69

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

Registration District No. 224

Primary Registration District No. 5305

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

1. PLACE OF DEATH:

(a) County Cooper  
(b) City or town Prairie Home T.P.  
(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 \_\_\_\_\_ (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

Eolo Franklin Coindexter

(b) If veteran, name war \_\_\_\_\_

(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 \_\_\_\_\_ years  
7. Birth date of deceased Sept 20 186  
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day  
73 1 17 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 \_\_\_\_\_  
(Burial, cremation, or removal) (Month) (Day) (Year)

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

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

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

19. (a) Nov 8-40 (b) A. L. Meredith  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 11 day 6  
year 1940 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)  
(c) Means of injury \_\_\_\_\_

23. Signature A. L. Meredith (M. D. or other) \_\_\_\_\_

Address Prairie Home Date signed \_\_\_\_\_

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

SUPPLEMENTAL COPY

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

