

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

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.

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED JAN 8 1941

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

41407

State File No. _____

Registration District No. 399

Primary Registration District No. 1002

Registrar's No. 4800

1. PLACE OF DEATH:

(a) County Jackson
 (b) City or town Kansas City
(If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution: Kansas City Tuberculosis Hospital.
(If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution 2 yrs. 4 mon.
(Specify whether years, months or days)
 In this community 9 years

3. (a) PRINT FULL NAME La Verne Pritchard
 (b) If veteran, name war No (c) Social Security No. No

4. Sex Female 5. Color or race white 6. (a) Single, widowed, married, divorced married
 6. (b) Name of husband or wife James C. Pritchard 6. (c) Age of husband for wife if alive 44 years
 7. Birth date of deceased July 23 1917
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>23</u>	<u>4</u>	<u>24</u>	hr. _____ min. _____

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

10. Usual occupation Housewife

11. Industry or business _____

MOTHER FATHER
 { 12. Name Hall, Clarence (deceased)
 { 13. Birthplace unknown
(City, town, or county) (State or foreign country)
 { 14. Maiden name Mathies, Ada
 { 15. Birthplace Okla.
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature K.C.T. B. Hospital (29)

(b) Address Leeds Sta., Kansas City

17. (a) Burial (b) Date thereof 12-27-40
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Temple

18. (a) Signature of funeral director Wagon & Son
 (b) Address Wagon & Son

19. (a) 12-17-40 (b) M. M. Brown
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson
 (c) City or town Kansas City
(If outside city or town limits write "RURAL")
 (d) Street No. 908 E. 25th.
(If rural, give location)
 (e) If foreign born, how long in U. S. A. ? _____ years

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec day 17
 year 1940 hour 5 minute 35/A M.

21. I hereby certify that I attended the deceased from August 5 1940 to Dec 17 1940;
 that I last saw her alive on Dec 17 1940
 and that death occurred on the date and hour stated above.

Immediate cause of death Pul Tbc

Due to 23

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? 361

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

23. Signature Chayer Med. Dept (M. D. or other)
 Address K.C. T.B. Hospital Date signed _____

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.....

Licensed Embalmer No.....

P. O. Address.....

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.