

7-39  
X21492  
FEB 19 MAR 19 1944

Registration District No. 204

Primary Registration District No. 4359

1. PLACE OF DEATH:

(a) County New Madrid County  
(b) City or town Rural  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: no  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 14 days  
(Specify whether years, months or days)

3. (a) PRINT FULL NAME Mildred May Pratt

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 S/O

6. (b) Name of husband or wife ✓ 6. (c) Age of husband or wife if alive ✓ years

7. Birth date of deceased January 20 1941  
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day  
no no 14 hr. \_\_\_\_\_ min.

9. Birthplace New Madrid County Missouri  
(City, town, or county) (State or foreign country)

10. Usual occupation \_\_\_\_\_

11. Industry or business ✓

MOTHER FATHER { 12. Name William Pratt  
13. Birthplace Mo  
(City, town, or county) (State or foreign country)

{ 14. Maiden name May Jones  
15. Birthplace N.C.  
(City, town, or county) (State or foreign country)

16. (a) Informant William Pratt

(b) Address Carson Mo Box 31

17. (a) Burial (b) Date thereof Feb. 3 1941  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Parma Cemetery

18. (a) Signature of funeral director T. C. Knight

(b) Address Parma Mo

19. (a) 5-3-41 (b) D. George Husted  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County New Madrid  
(c) City or town Rural  
(If outside city or town limit, 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 Feb day 3  
year 1941 hour 1:3 minute 45 P.M.

21. I hereby certify that I attended the deceased from 1-20-41, 19\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_; that I last saw him alive on 1-20-41, 19\_\_\_\_; and that death occurred on the date and hour stated above.

Immediate cause of death Broncho-pneumonia

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?  
524 (Specify type of place)  
While at work? ✓ (e) Means of injury \_\_\_\_\_  
23. Signature J. T. Gilliam M.D. (M. D. or other) \_\_\_\_\_  
Address Parma Mo Date signed 2-5-41

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

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

107

RECEIVED

District Health Officer No. 2

District File Number 341-349

Date Filed 3/12/46

FILED

**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.**

No. 2  
-1-4-41  
-17-39  
X25390

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. 7673

Registration District No. 605

Primary Registration District No. 4259

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

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

1. PLACE OF DEATH:  
(a) County New Madrid  
(b) City or town Osage  
(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) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME Mildred May Pratt  
3. (b) If veteran, name war \_\_\_\_\_  
3. (c) Social Security No. \_\_\_\_\_

MEDICAL CERTIFICATION  
20. DATE OF DEATH: Month Feb day 3  
year 1941 hour \_\_\_\_\_ minute \_\_\_\_\_ M.  
21. I hereby certify that I attended the deceased from \_\_\_\_\_  
\_\_\_\_\_, 19\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_;  
that I last saw him \_\_\_\_\_ live on \_\_\_\_\_, 19\_\_\_\_;  
and that death occurred on the date and hour stated above.

4. Sex 7 5. Color or race W 6. (a) Single, widowed, married, divorced 8  
6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_ years

Immediate cause of death Broncho pneumonia Duration 3  
Influenza 7

7. Birth date of deceased: (Month) \_\_\_\_\_ (Day) \_\_\_\_\_ (Year) \_\_\_\_\_  
8. AGE: Years \_\_\_\_\_ Months \_\_\_\_\_ Days 14 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

Due to \_\_\_\_\_  
Other conditions (Include pregnancy within 3 months of death) \_\_\_\_\_  
Major findings: Of operations \_\_\_\_\_  
Of autopsy \_\_\_\_\_

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

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 [Signature] (M. D. or other) MD  
Address [Address] Date signed 5-16-41

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

SUPPLEMENTARY

**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, fact should be so stated above.**