FILED MAY 16 1941

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 13729

Registration District No. 399 Primary Registration District No. 1002 Registrar's No. 1710

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

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 General Hospital (If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 3 Days (Specify whether

In this community 29 Years years, months or days)

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. 2010 East 47th Street Terrace (If rural, give location)

(e) If foreign born, how long in U. S. A.? -- 0 years.

3. (a) PRINT FULL NAME Mr. Charles U. Pratz

3. (b) If veteran, name war No

3. (c) Social Security No. None

4. Sex Male

5. Color or race White

6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Mrs. Evaleen Pratz

6. (c) Age of husband or wife if alive 70 years

7. Birth date of deceased July (Month) 21 (Day) 1869 (Year)

8. AGE: Years 71 Months 9 Days 7 If less than one day hr. min.

9. Birthplace Peoria County (City, town, or county) Illinois (State or foreign country)

10. Usual occupation Mail Clerk

11. Industry or business Railways

FATHER
12. Name William W. Pratz
13. Birthplace (City, town, or county) Pennsylvania (State or foreign country)

MOTHER
14. Maiden name Mary Dye
15. Birthplace (City, town, or county) Delaware (State or foreign country)

16. (a) Informant Mrs. Evaleen Pratz

(b) Address 2010 East 47th Street Terrace

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Apr. 30, 1941 (Month) (Day) (Year)

(c) Place: burial or cremation Mt. Moriah Cemetery

18. (a) Signature of funeral director O. H. Newcomers Sons

(b) Address 1401 Brush Creek Blvd.

19. Apr 30 1941 (Date received local registrar) (b) M. M. Crowe (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 28th year 1941 hour 6 minute 22 A. 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 — Duration

Subdural & subarachnoid central hemorrhage

Due to Laceration of the brain

Due to Fracture of the skull

Other conditions (Include pregnancy within 3 months of death) Auto traumatism

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) Accident

(b) Date of occurrence 4-25-41

(c) Where did injury occur? Jackson Co. Mo. U. S. Highway #50 (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)

While at work? (e) Means of injury

23. Signature [signature] (M. D. or other)

Address K. C. Mo. Date signed

(Licensed Embalmer's Statement on Reverse Side)

JUN 26 1941

170 C
98

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 George M. Collier

Licensed Embalmer No. 3839

P. O. Address K.C. 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, fact should be so stated above.

No. 2B
-2-21-40
I X22659

HOWENA MOORE

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 13729

Registration District No. ..... Primary Registration District No. ..... Registrar's No. 171D

SUPPLEMENTARY

1. PLACE OF DEATH:

(a) County Jackson

(b) City or town K. C.
(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 Charles U. Pratz

3. (b) If veteran, name war .....

3. (c) Social Security No. .....

4. Sex M

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 ..... hr. ..... min.

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

10. Usual occupation .....

11. Industry or business .....

FATHER
12. Name .....
13. Birthplace ..... (City, town, or county) ..... (State or foreign country)

MOTHER
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) 4/30/41 (Date received local registrar) (b) B. M. Crowe (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Apr. day 28-41
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 ..... Duration

Due to .....

Due to Auto traumatism

Other conditions .....
(Include pregnancy within 3 months of death)

Major findings:
Of operations ..... 170 C 72

Of autopsy U S Highway #50 - State Maintained

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) Accd.
(b) Date of occurrence 4-25-41
(c) Where did injury occur? Jackson Co. Mo (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place?
Highway 50 = Collision (Specify type of place)
While at work? ..... (e) Means of injury Truck & Automobile

23. Signature ..... (M. D. or other) .....
Address ..... Date signed .....