

FILED OCT 11 1941

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No.

31251

Registration District No. 125

Primary Registration District No. 3009

Registrar's No.

10

1. PLACE OF DEATH:

(a) County. Cape Girardeau
 (b) City or town. Cape Girardeau, Mo.
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution:
Family Home 414 6 Sprigg St 1
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution _____
 (Specify whether
 In this community all life
 years, months or days)

3. (a) PRINT FULL NAME Nancy Jane Pratter

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

4. Sex Female 5. Color or race W 6. (a) Single, widowed, married, divorced Widowed6. (b) Name of husband or wife Alfred Pratter (deceased) 6. (c) Age of husband or wife if alive _____ years7. Birth date of deceased Sept (Month) (Day) 1869 (Year)8. AGE: Years 72 Months 2 Days _____ If less than one day hr. _____ min.9. Birthplace White Water Missouri (City, town, or county) (State or foreign country)10. Usual occupation House wife

11. Industry or business _____

12. Name Jacob Pratter13. Birthplace West Virginia (City, town, or county) (State or foreign country)14. Maiden name Allen Smith15. Birthplace White Water Mo. (City, town, or county) (State or foreign country)16. (a) Informant's own signature Wm Young(b) Address Cape Girardeau Mo17. (a) Burial (b) Date thereof 9-9-41 (Burial, cremation, or removal) (Month) (Day) (Year)(c) Place: burial or cremation Passover Cemetery18. (a) Signature of funeral director J. H. Phillips(b) Address Cape Girardeau Mo19. (a) 9-9-41 (b) F. H. Phillips (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Cape Gir
 (c) City or town Cape Girardeau
 (If outside city or town limits, write "RURAL")
 (d) Street No. 1143 Sprigg St
 (If rural, give location)
 (e) If foreign born, how long in U. S. A. _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept day 7
year 1941 hour 8:30 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 Natural Cause Heart AttackDue to _____
Other conditions _____
(Includes 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?

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

23. Signature J. H. Phillips Crain
Address Jackson, Mo (M.D. or other)
Date signed 9/8/41

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

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 *W. H. Faith*.....

Licensed Embalmer No. *3568*.....

P. O. Address *Cape Girardeau*.....

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to complete 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. 3/251

Registration District No. 125

Primary Registration District No. 3009

Registrar's No. _____

1. PLACE OF DEATH

(a) County Cape Girardeau
(b) City or town Cape Girardeau
(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 _____
In this community all life (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) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME Nancy G. Protter

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

4. Sex F 5. Color or race W 6. (a) Single, widowed, married, divorced W

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

7. Birth date of deceased Sept 5 1869
(Month) (Day) (Year)

8. AGE: Years 72 Months 2 Days _____
(If less than one day _____ 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) 9-9-41 (b) [Signature]
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept Day _____
year 1941 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____
_____ 19____

that I last saw him/her live on _____, 19____
and that death occurred on the date and hour stated above.

Immediate cause of death _____

Due to Natural Causes Heart attack
Coronary Thrombosis

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 _____

SUPPLEMENTARY

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

S-31251 1941