2
-41
-39
K28390

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED OCT 10 1941

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 32678

Registration District No. 801 Primary Registration District No. 6044 Registrar's No.

1. PLACE OF DEATH:

(a) County Saline

(b) City or town Rural Salt Pond Twp. (If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: 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 68 yrs. years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Saline

(c) City or town Rural (If outside city or town limits, write "RURAL")

(d) Street No. Salt Pond Twsh. (If rural, give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3. (a) PRINT FULL NAME CAROLINE PRITCHARD

3. (b) If veteran, name war —

3. (c) Social Security No. —

4. Sex 1 FEMALE

5. Color or race WHITE

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

6. (b) Name of husband or wife LOGAN PRITCHARD

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

7. Birth date of deceased SEPT (Month) 3 (Day) 1865 (Year)

8. AGE: Years 76 Months Days 14 If less than one day hr. min.

9. Birthplace (City, town, or county) 1 Ky. (State or foreign country)

10. Usual occupation AT HOME.

11. Industry or business HOME DUTIES

FATHER
12. Name AUGUST COOK.
13. Birthplace (City, town, or county) 4 GERMANY (State or foreign country)

MOTHER
14. Maiden name CORDELIA OSER
15. Birthplace (City, town, or county) 1 PA. (State or foreign country)

16. (a) Informant Mrs. Arthur Truntman

(b) Address Sweet Springs Mo.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/19/41 (Month) (Day) (Year)

(c) Place: burial or cremation Fairview Cemetery

18. (a) Signature of funeral director R C Casler

(b) Address Sweet Springs Mo.

19. (a) 9/19/41 (Date received local registrar) (b) R Q Jones (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept day 17th year 1941 hour 10 minute 45 A M.

21. I hereby certify that I attended the deceased from Feb. 15 1940, to Sept 17, 1941 that I last saw her alive on Sept. 15 1941; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Uremia	week
Due to Chronic nephritis	
Due to	
Other conditions Diabetes (Include pregnancy within 3 months of death)	
Hypertension	

Major findings:
Of operations
Of autopsy

61

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? (Specify type of place)

While at work? (e) Means of injury

23. Signature Leoburn Ellis (M. D. or other)

Address Sweet Spring Mo. Date signed 9/18/41

98 (Licensed Embalmer's Statement on Reverse Side)

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. 3573

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.