

No. 2
1-4-41

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

Dr C.B. Ehlert 10-257

D MAR 17 1943 122 318

State File No.

Registration District No.

Primary Registration District No. 5455

Registrar's No.

1. PLACE OF DEATH: **GREENE**

(a) County: **Greene**

(b) City or town: **Springfield, Rural**
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: **Siler Golf Course 3**
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution **None**
(Specify whether years, months or days)

In this community **66 years**
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State: **Missouri** (b) County: **Greene**

(c) City or town: **Springfield,**
(If outside city or town limits, write "RURAL")

(d) Street No.: **939 N. Grant**
(If rural, give location)

(e) Citizen of foreign country? **1** (Yes or No)
If yes, name country: _____

3. (a) PRINT FULL NAME: **John A. Pranter**

3. (b) If veteran, name war: **None**

3. (c) Social Security No.: **Unknown**

4. Sex: **Male**

5. Color or race: **White**

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

6. (b) Name of husband or wife: **Caroline S. Pranter**

6. (c) Age of husband or wife if alive: **Unknown** years

7. Birth date of deceased: **February 17, 1876**
(Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
66	11	19	hr. min.

9. Birthplace: **Springfield, Missouri**
(City, town, or county) (State or foreign country)

10. Usual occupation: **Retired Salesman**

11. Industry or business: **Hardware Company**

12. Name: **Frederick Pranter**

13. Birthplace: **Unknown Austria 18**
(City, town, or county) (State or foreign country)

14. Maiden name: **Wilhemina Leetz**

15. Birthplace: **Unknown Austria 4**
(City, town, or county) (State or foreign country)

16. (a) Informant: **Mrs. Caroline Pranter**

(b) Address: **Springfield, Missouri**

17. (a) **Burial** (Burial, cremation, or removal) (b) Date thereof: **Feb. 9, 1943**
(Month) (Day) (Year)

(c) Place: burial or cremation: **Hazelwood Cemetery**

18. (a) Signature of funeral director: **Alma Lohmeyer Funeral Home**

(b) Address: **Springfield, Missouri**

19. (a) **2-13-1943** (Date received local registrar) (b) **Glorance Britain** (Registrar's signature)

1241 (Licensed Embalmer's Statement on Reverse Side)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **February** day **6th**
year **1943** hour **3:30** minute **P.** M.

21. I hereby certify that I attended the deceased from **May 1941** to **Feb 6, 1943**
that I last saw him ~~alive~~ **alive** on **Jan 31, 1943**
and that death occurred on the date **February 6, 1943**

Immediate cause of death: **Asp. Attack of Arteriosclerosis**

Due to: **Disease of Coronary Vessels**

Found: **Verified by Electrocardiogram**

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

Major findings: **948**
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? _____

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

23. Signature: **C.B. Ehlert** (M. D. certifier)
Address: **318 1/2 College St** Date signed: **2-9-43**

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

MOTHER FATHER

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

RECEIVED

Greene County Health Office,

County File Number

43-3-25

Date Filed

2/15/43

NOV 20 1944

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

Harlow Knabb

Licensed Embalmer No. 4065

P. O. Address *Springfield*

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.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 5-10-43

Registration District No. (122)

Primary Registration District No. (5456)

Registrar's No. _____

1. PLACE OF DEATH:

(a) County Greene
(b) City or town Springfield Rural
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Siler Golf Course
(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 John A. Pranter

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 Feb 17 (Month) (Day) (Year)

8. AGE: Years 66 Months 16 Days no. (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 _____ (Month) (Day) (Year)
(Burial, cremation, or removal)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) 2-13-43 (b) Florence Brittain
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb day 17 year 1943 hour _____ minute _____ M.

21. I hereby certify that I attended the decedent from _____ to _____, 19____; that I last saw him/her alive on _____, 19____; and that death occurred on the date and hour stated above. Immediate cause of death _____

Due to _____

Due to _____

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

Major findings: Of operations _____

Of autopsy _____

Duration

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)

(b) Did injury occur in or about home, on farm, in industrial place, in public place? _____

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

23. Signature _____ (M. D. or other)

Address _____ Date signed _____

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

SUPPLEMENTARY

S-10297