DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED MAY 3 1943

Registration District No. 4

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

Primary Registration District No. 5734

State File No. 13772

Registrar's No. 395

1. PLACE OF DEATH:

(a) County Buchanan

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

(c) Name of hospital or institution: R.F.D. # 6 / Washington Twp
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution Lifetime (Specify whether
In this community Lifetime years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Buchanan 11

(c) City or town St. Joseph (Rural) 0
(If outside city or town limits, write "RURAL")

(d) Street No. R.F.D. # 6
(If rural, give location)

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

If yes, name country 0

3. (a) PRINT FULL NAME Angelina Pratt

3. (b) If veteran, name war None

3. (c) Social Security No. None

4. Sex Female

5. Color or race White

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

6. (b) Name of husband or wife Horton

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

7. Birth date of deceased May (Month) 15, (Day) 1859 (Year)

8. AGE: Years 83 | Months 10 | Days 9 | If less than one day ___ hr. ___ min.

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

10. Usual occupation Housekeeper (Pension)

11. Industry or business Home

12. Name David Tabor

13. Birthplace New York (City, town, or county) 1 (State or foreign country)

14. Maiden name Elizabeth Earl

15. Birthplace New York (City, town, or county) 1 (State or foreign country)

16. (a) Informant Idora Noland (Daughter)

(b) Address Route # 6, St. Joseph, Mo.

(a) Burial (Burial, cremation, or removal) (b) Date thereof 3/29/43 (Month) (Day) (Year)

(c) Place: burial or cremation King Hill Cemetery

(a) Signature of funeral director John E. Kupp

(b) Address 6054 Pryor Ave., City

19. (a) 3-29-43 (Date received local registrar) (b) Rose Hergoz (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 26 year 1943 hour 5 minute P. M

21. I hereby certify that I attended the deceased from March 22, 1943, to March 26, 1943 that I last saw her alive on March 25, 1943 and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Broncho-pneumonia	4 da.
Due to Myocardial Insufficiency Arteriosclerosis	?
~~Due to~~ Mitral valve insufficiency	
Other conditions Senility (Include pregnancy within 3 months of death)	92 P

Major findings:
Of operations none

Of autopsy none

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 C. S. Grant (M. D. or other) MD

Address St. Joseph, Mo Date signed 3-29-43

1233

V. S. No. 2-A
50M—2-27-41
1 X27167

MARGIN RESERVED FOR BINDING

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

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

DEPARTMENT OF COMMERCE
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STANDARD CERTIFICATE OF DEATH

State File No......

Registration District No..... Primary Registration District No..... *Registrar's No.*.....

1. PLACE OF DEATH:

(*a*) County.....

(*b*) City or town.....
(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 years, months or days)
In this community.....

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 N

If yes, name country.....

3. (*a*) **PRINT FULL NAME**.....

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

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

4. Sex.....

5. Color or race.....

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

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*) ..... (Date received local registrar) (*b*) ..... (Registrar's signature)

MEDICAL CERTIFICATION

20. **DATE OF DEATH:** Month.....day.....
year.....hour.....minute.....

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..... *Dura*
.....
.....
Due to.....
.....
Due to.....
.....
Other conditions.....
(Include pregnancy within 3 months of death)
.....
Major findings:
Of operations.....
.....
Of autopsy.....
.....

PHYSIC
Underl the cause which de should charged tistically

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) (St
(*d*) Did injury occur in or about home, on farm, in industrial place, in public
.....
While at work?..... (Specify type of place) (*e*) Means of injury.....

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

MARGIN RESERVED FOR BINDING

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

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

V. S. No. 2-A
50M—2-27-41
J X27167

I hereby certify that the body whoe's name appears on the reverse side of this certificate was embalmed by me

John E. Rudolph

3986
St. Joseph, Missouri

MO.. _____ 194___

_____

_____

NT WITH

ERAL HOME

UPP, PROP.

PHONE 8-0056