

25949

State File No. _____

Registrar's No. 102

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

No. 2-43
17-39
X35697

ED AUG 6 1943
Registration District No. 316

Primary Registration District No. 3059

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

1. PLACE OF DEATH:

(a) County St. Francois

(b) City or town Bonne Terre
(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 (Specify whether)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County St. Francois

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

(d) Street No. Route 1
(If rural, give location)

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

If yes, name country _____

3. (a) PRINT FULL NAME FRANKLIN ISAAC PRATTE

3. (b) If veteran, name war _____ 3. (c) Social Security No. 494-05-1841

4. Sex M 5. Color or race W 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 April 30 1878
(Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
<u>65</u>	<u>2</u>	<u>22</u>	hr. _____ min. _____

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

10. Usual occupation Retired

11. Industry or business _____

12. Name Clay Pratte

13. Birthplace Bonne Terre Missouri
(City, town, or county) (State or foreign country)

14. Maiden name Sarah Ellen Richardson

15. Birthplace French Village Missouri
(City, town, or county) (State or foreign country)

16. (a) Informant Mr. Oran Roberts

(b) Address Bonne Terre Mo

17. (a) Burial (b) Date thereof 7-14-43
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Marion Chapel

18. (a) Signature of funeral director Benham and Co

(b) Address 313 Benham Bonne Terre Mo

19. (a) July 19, 1943 (b) Sydia Buhmester
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 12th year 1943 hour 1 minute 45 P. M.

21. I hereby certify that I attended the deceased By Request Physician July 12th 1943

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

Immediate cause of death Natural Causes
my verdict; the deceased came to his death by natural

Due to caused submission to the jury

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 Clarence Claywell Carroll
Bonne Terre Mo (M.D. or other) Address _____ Date signed 7-12-43

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

1196

RECEIVED

District Health Officer No. _____

District File Number 843-282

Date Filed 8-5-43

" 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

Clarence J. Claywell

Licensed Embalmer No. 3706

P. O. Address Bonne Terre 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.

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 16 5 1943

Registration District No. 316

Primary Registration District No. 3059

Registrar's No. 102

1. PLACE OF DEATH:

(a) County St. Francois
(b) City or town Bonne Terre
(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..... (Specify whether
years, months or days)

3. (a) PRINT FULL NAME Franklin D. Pratto

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 W

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

7. Birth date of deceased..... April 20, 1911
(Month) (Day) (Year)

8. AGE: Years 65 Months 2 Days mo 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) (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)

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.....

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July at 12 minute. M.
year 1943

21. I hereby certify that I attended the deceased from..... 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

Due to.....

Due to.....

Other conditions (Include pregnancy within 3 months of death) 83a1

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) (e) Means of injury.....

23. Signature Dorene Clayton Colman (M.D. or other)

Address Bonne Terre Mo Date signed.....

SUPPLEMENTARY

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

