

SEP 14 1943  
Registration District No. \_\_\_\_\_

Primary Registration District No. 4178

Registrar's No. 13

1. PLACE OF DEATH:

(a) County Dunklin  
(b) City or town Holcomb, Mo.  
(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 13 yrs  
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County Dunklin  
(c) City or town Holcomb, Mo.  
(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 Abner Steve Prewitt  
3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug day 28  
year 1943 hour 3:35 P.M. minute \_\_\_\_\_ M.  
21. I hereby certify that I attended the deceased from 10-18-41  
1941 to 8-25-43 1943  
that I last saw him alive on 8-25 1943  
and that death occurred on the date and hour stated above.

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

Immediate cause of death  
Apoplexy from hypertension  
Arteriosclerosis, Chronic  
Due to hypertension + arterial insufficiency  
Due to \_\_\_\_\_  
Other conditions (Include pregnancy within 3 months of death) \_\_\_\_\_

8. AGE: Years Months Days If less than one day  
68 3 17 \_\_\_\_\_ hr. \_\_\_\_\_ min.

9. Birthplace Hardy, Ark. (City, town, or county) (State or foreign country)

10. Usual occupation Farming

11. Industry or business  
12. Name Abner Prewitt  
13. Birthplace Tenn. (City, town, or county) (State or foreign country)  
14. Maiden name P.K.  
15. Birthplace P.K. (City, town, or county) (State or foreign country)

Major findings: Of operations \_\_\_\_\_  
Of autopsy \_\_\_\_\_  
PHYSICIAN  
Underline the cause to which death should be charged statistically.

16. (a) Informant Edo Prewitt  
(b) Address Holcomb, Mo. RT. 1.  
17. (a) Burial (b) Date thereof Aug. 30, 1943  
(Burial, cremation, or removal) (Month) (Day) (Year)  
(c) Place: burial or cremation Lloyd Pharmacy  
18. (a) Signature of funeral director W. H. Foley  
(b) Address Piggott, Ark.  
19. (a) 9-4-43 (b) Mrs. Mabel Blankenship  
(Date received local registrar) (Registrar's signature)

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 W. E. Turner (M. D. or other) \_\_\_\_\_  
Address Piggott, Ark. Date signed 8-29-43

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

MOTHER FATHER

RECEIVED

District Health Office No. 2,

District File Number 943-1130

Date Filed 9-13-48

---

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.....

W. H. Grady....., Registered Apprentice No.....  
working under my personal supervision.

Signed.....

Licensed Embalmer No.....

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.**