

No. 2
2-43
-1-7-39
35897

FILED NOV 8 1944
Registration District No. **3005**

Primary Registration District No. **3005**

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

1. PLACE OF DEATH: **Bates.**
 (a) County **Bates.**
 (b) City or town **Butler, Mo.**
(If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution: **Butler Memorial Hosp.**
(If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution **8 days.**
(Specify whether
 In this community **0**
years, months or days)

2. USUAL RESIDENCE OF DECEASED:
 (a) State **Mo.** (b) County **St. Clair**
 (c) City or town **Schell City, Mo.**
(If outside city or town limits, write "RURAL")
 (d) Street No. **Rural**
(If rural, give location)
 (e) Citizen of foreign country? **1** (Yes or No)
 If yes, name country _____

3. (a) PRINT FULL NAME **FRANK PROUGH.**
 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 **Single.**
 6. (b) Name of husband or wife _____
 6. (c) Age of husband or wife if alive _____ years
 7. Birth date of deceased **Jan. 29 1885**
(Month) (Day) (Year)

8. AGE: Years **69** Months **8** Days **16**
 If less than one day hr. _____ min. _____

9. Birthplace **St. Clair Co.** **0**
(City, town, or county) (State or foreign country)

10. Usual occupation **Farmer.**

11. Industry or business _____

MOTHER FATHER
 12. Name **Corza Prough.**
 13. Birthplace **Indiana**
(City, town, or county) (State or foreign country)
 14. Maiden name **Katherine Hill.**
 15. Birthplace **Ohio.**
(City, town, or county) (State or foreign country)

16. (a) Informant **Bertha Prough.**
 (b) Address **Schell City, Mo.**

17. (a) **Burial** (b) Date thereof **Oct. 9, 1944**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Laborville, Mo.**

18. (a) Signature of funeral director **James Siler**

(b) Address **1400 S. Sprague Mo.**

19. (a) **Oct. 8, 1944** (b) **Pauline Compton**
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Oct** day **7**
 year **1944** hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from **Mar 1**
 19 **44** to **Oct 7** 19 **44**
 that I last saw him alive on **Oct 6** 19 **44**
 and that death occurred on the date and hour stated above.

Immediate cause of death **Heart failure**
uremic coma
apoplexy
Hypertension
 Due to _____

Due to **Chronic nephritis**

Other conditions **131**
(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)

(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 **A. R. Harniss** (M. D. or other) **MD**
 Address **Appleton City Mo.** Date signed **10-8-44**

1306

RECEIVED
L. H. ... Officer No. 7,
District No. 10-44-1224
Date Filed 11-7-44

MAY 7 1951

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 O. B. Sanders

Licensed Embalmer No. 3250

P. O. Address Edwards Springs

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.