

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. _____

FILED NOV 10 1944
340

Registration District No. 340

Primary Registration District No. 6151

Registrar's No. 30

1. PLACE OF DEATH:

(a) County Stoddard

(b) City or town Elk Township
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: None
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution None
(Specify whether)

In this community 67 yrs.
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Stoddard

(c) City or town Rural 7 mi N.E. of Parma
(If outside city or town limits, write "RURAL") 103

(d) Street No. _____ (If rural, give location)

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

3. (a) PRINT FULL NAME JOHN-ROBERT-PRITT

3. (b) If veteran, name war No. 3. (c) Social Security No. No.

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

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

7. Birth date of deceased Nov 18 1892
(Month) (Day) (Year)

8. AGE: Years 71 Months 10 Days 17 If less than one day _____ hr. _____ min.

9. Birthplace State of Ill.
(City, town, or county) (State or foreign country)

10. Usual occupation Farming

11. Industry or business _____

12. Name John Pritt

13. Birthplace unknown
(City, town, or county) (State or foreign country)

14. Maiden name unknown

15. Birthplace unknown
(City, town, or county) (State or foreign country)

16. (a) Informant Mr. John R. Pritt

(b) Address Parma St

17. (a) Rural (b) Date thereof 10 9 44
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Malden Mo

18. (a) Signature of funeral director Walter J. Smith

(b) Address Parma Mo

19. (a) Oct 18 46 (b) Carrie Miller
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct day 6
year 1944 hour 7 minute 30 P. M.

21. I hereby certify that I attended the deceased from Sept 10 1944 to Oct 16 1944
that I last saw him alive on Sept 28 1944
and that death occurred on the date and hour stated above.

Immediate cause of death Palenomenia of Gall Bladder probably
Duration 2 yrs

Due to _____
Due to 464

Other conditions Jaundice probably
(Include pregnancy within 3 months of death) 3 mo

Major findings: none
Of operations _____
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?

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

23. Signature E. E. Mitchell (M. D. or other) M.D.
Address Malden Mo Date signed 10/9/44

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

13
0
0

MOTHER FATHER

1135

RECEIVED

District Health Office No. 2,

District File Number 114-1477

Date Filed 11-6-44

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 Lynna Steele

Licensed Embalmer No. 7476

P. O. Address Hexter Md

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.