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I—11-10-39
v. 5-17-39
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED FEB 16 1945

MISSOURI STATE BOARD OF HEALTH

# STANDARD CERTIFICATE OF DEATH

State File No.

Registration District No. 23086 Primary Registration District No. 5312 5322 Registrar's No. 36

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

28
1
0

**1. PLACE OF DEATH:**

(a) County CRAWFORD

(b) City or town CUBA. (RURAL) Bentonville
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: 1
(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)

**2. USUAL RESIDENCE OF DECEASED:**

(a) State Missouri (b) County Crawford 28

(c) City or town Cuba, Rural 1
(If outside city or town limits, write "RURAL") 0

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

(e) If foreign born, how long in U. S. A.? years.

3. (a) PRINT FULL NAME ALPHA PRITCHETT

3. (b) If veteran, name war Yes

3. (c) Social Security No.

4. Sex MALE

5. Color or race WHITE

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

6. (b) Name of husband or wife MARTHA PRITCHETT

6. (c) Age of husband or wife if alive 69 years

7. Birth date of deceased Oct. 7, 1886
(Month) (Day) (Year)

8. AGE:

| Years | Months | Days | If less than one day |
|---|---|---|---|
| 58 | 4 | 1 | hr. min. |

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

10. Usual occupation farming

11. Industry or business farming

FATHER
12. Name ROBERT PRITCHETT
13. Birthplace MISSOURI
(City, town, or county) (State or foreign country)

MOTHER
14. Maiden name SARAH JOHNSON
15. Birthplace Unknown
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Martha Pritchett

(b) Address Cuba, Missouri

17. (a) Burial (b) Date thereof Feb. 11, 45
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Leasburg, Mo.

18. (a) Signature of funeral director Chas. P. Hoffer

(b) Address Sullivan, Missouri.

19. (a) Feb. 10, 1945 (Date received local registrar) G. G. A. Herzog (Registrar's signature)

**MEDICAL CERTIFICATION**

20. DATE OF DEATH: Month Feb. day 8
year 1945 hour 6 minute 45 P.M.

21. I hereby certify that I attended the deceased from 7 January, 1945, to 3 Feb., 1945; that I last saw him alive on 3 Feb., 1945; and that death occurred on the date and hour stated above.

| | Duration |
|---|---|
| Immediate cause of death Cardiac failure | |
| Due to Chronic myocarditis | 10 yrs. |
| Due to | |
| Other conditions (Include pregnancy within 3 months of death) | |
| 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?
(Specify type of place)

While at work? (e) Means of injury

23. Signature William Obey D.O.
Address Steelville Mo. Date signed 10 Feb 1945

206

(Licensed Embalmer's Statement on Reverse Side)

FEB 20 1945

MAR 20 1945

MAY 4 1945

**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 Edgar W. Laffoon

Licensed Embalmer No. 73394

P. O. Address Sullivan 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, above space should be left blank.**