DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED APR 14 1945

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 10426

Registration District No. 2/5 Primary Registration District No. 3053 Registrar's No. 35

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

1. PLACE OF DEATH:

(a) County ~~Dent~~ Phelps

(b) City or town ~~Rural~~ Rolla (If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution McFarland Hosp. (If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 2 days (Specify whether

In this community 35 years. years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County Shannon

(c) City or town Timber, Rural (If outside city or town limits, write "RURAL")

(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 Samuel Hugh Piatt

3. (b) If veteran, name war

3. (c) Social Security No. 491-16-17-20

4. Sex M.

5. Color or race W

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

6. (b) Name of husband or wife Opal Piatt

6. (c) Age of husband or wife if alive 29 years

7. Birth date of deceased 6 (Month) 27 (Day) 1909 (Year)

8. AGE: Years 35 Months 8 Days 22 If less than one day hr. min.

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

10. Usual occupation Labor

11. Industry or business

FATHER
12. Name Oliver Piatt
13. Birthplace Dent, Co. Mo. (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name Blanche Bragg
15. Birthplace Shannon Co. Mo. (City, town, or county) (State or foreign country)

16. (a) Informant Opal Piatt

(b) Address Timber, Mo.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-21-45 (Month) (Day) (Year)

(c) Place: burial or cremation Piatt Cemetery

18. (a) Signature of funeral director Hobson & Grantham

(b) Address Salem, Mo.

19. (a) 3-20-1945 (Date received local registrar) (b) Ellis Maeglo (Registrar's signature)

1092

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 19 year 1945 hour 3 minute 00 P.M.

21. I hereby certify that I attended the deceased from Seen only after accident, 19 to 19 that I last saw him alive on 3-18-45, 19 and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Cerebral Concussion	2 days
Due to	
Due to Head Injury	
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) Auto Accident

(b) Date of occurrence 3-17-45

(c) Where did injury occur? (City or town) Dent (County) Mo (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? along highway (Specify type of place)

While at work? (e) Means of injury Auto

23. Signature M. M. Hart MD (M.D. or other) MD

Address Date signed

(Licensed Embalmer's Statement on Reverse Side) Deputy Coroner 3-20-45

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

me, Registered Apprentice No.

working under my personal supervision.

Signed Orde E Licklick

Licensed Embalmer No. 3546

P. O. Address St James M

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.

2B
-45
43880

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 10476

Registration District No. 275 Primary Registration District No. 3053 Registrar's No. 35

1. PLACE OF DEATH:

(a) County: Phelps
(b) City or town: Rolla
(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 years, months or days)
In this community

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

3. (a) PRINT FULL NAME: Samuel H. Pratt

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: M

6. (b) Name of husband or wife

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

7. Birth date of deceased: June (Month) 2 (Day) 1904 (Year)

8. AGE: Years 35 Months Days If less than one day hr. min.

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

10. Usual occupation

11. Industry or business

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

MOTHER
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)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb. Day 9 year 1944 hour minute M.

21. I hereby certify that I attended the deceased from , 19 , to , 19 ; that I last saw h alive on , 19 ; and that death occurred on the date and hour stated above.

Immediate cause of death — Duration

Due to: Auto & truck

Due to: Collided

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): Auto Accident
(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 (M. D. or other)
Address Date signed

SUPPLEMENTARY

10426