S. No. 2
M—5-43
v. 5-17-39
I X36671

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

FILED OCT 23 1946

State File No. 33290

Registration District No. 128

Primary Registration District No. 2000

Registrar's No. 803

1. PLACE OF DEATH:

(a) County GREENE

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

(c) Name of hospital or institution:
Burge Hospital 0
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution ..... (Specify whether
In this community ..... Life
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County Greene 39 2

(c) City or town Springfield 6
(If outside city or town limits, write "RURAL")

(d) Street No. 2135 Taylor 0
(If rural, give location)

(e) Citizen of foreign country? No. (Yes or No)

If yes, name country .....

3. (a) PRINT FULL NAME Rosa Prater

3. (b) If veteran, name war None

3. (c) Social Security No. None

4. Sex Female /

5. Color or race White

6. (a) Single, widowed, married, divorced Married /

6. (b) Name of husband or wife William T. Prater

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

7. Birth date of deceased February 27, 1867
(Month) (Day) (Year)

8. AGE: ✓

Years	Months	Days	If less than one day
79	7	7	..... hr. ..... min.

9. Birthplace Greene County Mo. 0
(City, town, or county) (State or foreign country)

10. Usual occupation House Wife

11. Industry or business At Home

FATHER
12. Name William Williams
13. Birthplace unk Mo. 0
(City, town, or county) (State or foreign country)

MOTHER
14. Maiden name Sarah France Cox
15. Birthplace unk Mo. 0
(City, town, or county) (State or foreign country)

16. (a) Informant Matt C. Prater
(b) Address Springfield Mo.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 10- 6-1946
(Month) (Day) (Year)
(c) Place: burial or cremation New Hope Cem.

18. (a) Signature of funeral director J. W. Klingner & Co
(b) Address Springfield Mo.

19. (a) 10-6-46 (Date received local registrar) (b) W E Handley MD (Registrar's signature)

MEDICAL CERTIFICATION

20. **DATE OF DEATH:** Month Oct. day 4
year 1946 hour 1 minute 47 P. M.

21. I hereby certify that I attended the deceased from Aug 24, 1946, to Oct 4, 1946
that I last saw her alive on 10 - 4, 1946
and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Pulmonary Embolus	24 hrs
Due to Coronary Occlusion	2 mos
Due to Arteriosclerosis	20 yrs
Other conditions (Include pregnancy within 3 months of death)	

Major findings:
Of operations — 94A
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 0

23. Signature [signature] (M. D. or other) MD
Address 4501 E. Council Date signed 10-4-46

111

(Licensed Embalmer's Statement on Reverse Side)

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 Ogle Slone Jr.

Licensed Embalmer No. 4176

P. O. Address Springfield

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.