

FILED FEB 28 1947
Registration District No. 2100

Primary Registration District No. 6225

State File No. _____

Registrar's No. 27

1. PLACE OF DEATH:

(a) County Vernon
(b) City or town Merado R
(c) Name of hospital or institution: State Hospital 2
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____
In this community 10 yrs 7 mos. 26 days (Specify whether years, months or days)

3. (a) PRINT FULL NAME Albert Prater

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

4. Sex M 5. Color or race W 6. (a) Single divorced Married

6. (b) Name of husband or wife D.K. 6. (c) Age of husband or wife if alive ? years

7. Birth date of deceased 6-16-1868
(Month) (Day) (Year)

8. AGE: Years 81 Months 8 Days 3 If less than one day hr. min.

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

10. Usual occupation Farming

11. Industry or business _____

12. Name Samuel Prater

13. Birthplace Madison Co Ark (City, town or county) (State or foreign country)

14. Maiden name Sarah Ray

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

16. (a) Informant Records (b) Address State Hospital

17. (a) Burial (b) Date thereof 2-21-47
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Shilo

18. (a) Signature of funeral director Monroe - Jensen
(b) Address Madison Co Ark

19. (a) 2-20-47 (b) Richard Vance
(Date received local registrar) (Registrar's signature)

By [Signature] (Licensed Embalmer's Statement on Reverse Side)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Boone 108
(c) City or town South Greenfield 0
(If outside city or town limits, write "RURAL")
(d) Street No. Rural 0
(If rural, give location)
(e) If foreign born, how long in U. S. A? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 2 day 19
year 1947 hour 6 minute A M.

21. I hereby certify that I attended the deceased from 1-6-1946 to 2-19-1947
that I last saw him alive on 2-18-1947
and that death occurred on the date and hour stated above.

Immediate cause of death _____

Due to Generalized Arteriosclerosis D.K.

Due to Senile Deterioration D.K.

Other conditions (include pregnancy within 8 months of death) _____

Major findings Of operations: CA
Of autopsy _____

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 0

23. Signature W. Bunch (M. D. or other) _____
Address State Hospital # 3 Date signed 2-19-47

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

CT-92-2
671-CT-1

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 _____

Licensed Embalmer No. _____

P.O. Address _____

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.