

THE DIVISION OF HEALTH OF MISSOURI  
 STANDARD CERTIFICATE OF DEATH

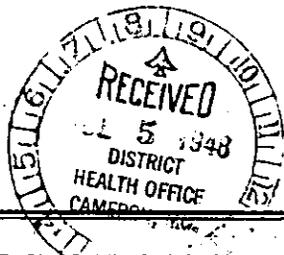
State File No. ....

 BIRTH NO. 33756-49 REG. DIST. NO. 133 PRIMARY REG. DIST. NO. 3022 Registrar's No. 818

1. PLACE OF DEATH a. COUNTY <u>Harrison</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <u>Mo</u> b. COUNTY <u>Harrison</u>			
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Bethany</u>		c. LENGTH OF STAY (in this place)		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Bethany Mo</u>		1	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>1</u>				d. STREET ADDRESS (If rural, give location) <u>1</u>			
3. NAME OF DECEASED (Type or Print) a. (First) <u>Patricia Joan</u> b. (Middle) <u>Daughter</u> c. (Last) <u>Al Pratt</u>			4. DATE OF DEATH (Month) (Day) (Year) <u>June 26 1949</u>				
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Single</u>	8. DATE OF BIRTH <u>June 26 1949</u>	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	IF UNDER 1 YEAR Days	IF UNDER 1 YEAR Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Bethany Mo</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13a. FATHER'S NAME <u>Al Pratt</u>		13b. MOTHER'S MAIDEN NAME <u>Leona Mae Burns</u>		14. NAME OF HUSBAND OR WIFE			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>Al Pratt Bethany Mo</u>			
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)  *This does not mean the mode of dying, such as heart failure, asphyxia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Pneumonia</u> ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>What's 6 months pregnancy</u> DUE TO (c) II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.				INTERVAL BETWEEN ONSET AND DEATH <u>77h 0x</u>	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT SUICIDE HOMICIDE (Specify)		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (m.)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>June 26, 1949</u> , to <u>June 26, 1949</u> ; that I last saw the deceased alive on <u>June 26, 1949</u> , and that death occurred at <u>3:00 P.M.</u> from the causes and on the date stated above.							
23a. SIGNATURE (Degree or title) <u>L. M. Pimpot D.O.</u>			23b. ADDRESS <u>Bethany Mo</u>			23c. DATE SIGNED <u>June 27, 1949</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify)		24b. DATE <u>June 27 1949</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Altamont Cemetery</u>		24d. LOCATION (City, town, or county) (State) <u>Altamont Mo</u>		
DATE REC'D BY LOCAL REG. <u>June 27-49</u>		REGISTRAR'S SIGNATURE <u>Edith Cornelius</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Joe E. Wheeler</u>		ADDRESS <u>Bethany Mo</u>	

(Licensed Embalmer's Statement on Reverse Side)

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



**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was <sup>not</sup> embalmed by me, or by \_\_\_\_\_

Student Embalmer No. \_\_\_\_\_

working under my personal supervision.

Signed \_\_\_\_\_

*Joe E. Wheeler*

Licensed Embalmer No. \_\_\_\_\_

*3512*

Signed \_\_\_\_\_

Student Embalmer

P. O. Address \_\_\_\_\_

*Orlean 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, fact should be so stated above.