

THE DIVISION OF HEALTH OF MISSOURI  
**FILED APR 18 1951 STANDARD CERTIFICATE OF DEATH**

15249  
 State File No. \_\_\_\_\_

BIRTH NO. _____		REG. DIST. NO. <u>333</u>		PRIMARY REG. DIST. NO. <u>3074</u>		Registrar's No. <u>69</u>	
1. PLACE OF DEATH a. COUNTY <u>Scott</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>New Madrid</u>			
b. CITY (If outside corporate limits, write RURAL and give township) <u>Sikeston</u>		c. LENGTH OF STAY (in this place) <u>1 wk.</u>		c. CITY (If outside corporate limits, write RURAL and give township) <u>Lilbourn</u>		<u>1920</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>Delta Comm. Hosp.</u>				d. STREET ADDRESS (If rural, give location) <u>1</u>			
3. NAME OF DECEASED (Type or Print) a. (First) <u>Charles</u> b. (Middle) <u>Edward</u> c. (Last) <u>Pratt</u>			4. DATE OF DEATH (Month) (Day) (Year) <u>March 25 1951</u>				
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>	8. DATE OF BIRTH <u>Sept. 6 1884</u>		9. AGE (In years last birthday) <u>66</u>	IF UNDER 1 YEAR Months <u>6</u> Days <u>19</u>	IF UNDER 24 HRS. Hour <u></u> Min. <u></u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Veterinarian</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Veterinarian</u>		11. BIRTHPLACE (State or foreign country) <u>Sikeston, Missouri</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13a. FATHER'S NAME <u>Joseph Ad Pratt</u>		13b. MOTHER'S MAIDEN NAME <u>Mollie Greer</u>		14. NAME OF HUSBAND OR WIFE <u>Leora Pratt</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No.</u>	16. SOCIAL SECURITY NO. <u>None</u>	17. INFORMANT'S SIGNATURE OR NAME <u>Bill Pratt, Sikeston, Mo.</u>					ADDRESS
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, asthenia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH <u>1 week</u>
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Cerebral apoplexy</u>						
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Hypertensive Cardiovascular disease</u>						?
	DUE TO (c)						
	II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.						
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION  <u>443X</u>						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21a. ACCIDENT (Specify) <u>SUICIDE</u>		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) (Min.)		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>3/19</u> , 19 <u>51</u> , to <u>March 25</u> , 19 <u>51</u> , that I last saw the deceased alive on <u>3/25</u> , 19 <u>51</u> , and that death occurred at <u>10:25</u> A.M., from the causes and on the date stated above.							
23a. SIGNATURE <u>Wm. C. Cutchlow M.D.</u> (Degree or title)				23b. ADDRESS <u>Sikeston, Mo.</u>		23c. DATE SIGNED <u>April 13 1951</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	24b. DATE <u>3-27-51</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Memorial Park</u>		24d. LOCATION (City, town, or county) (State) <u>Sikeston, Missouri</u>			
DATE REC'D BY LOCAL REG. <u>Apr 16 51</u>	REGISTRAR'S SIGNATURE <u>Mrs. Ella Hunter</u>			25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Ponder Funeral Home-Lilbourn, Mo.</u>			

(Licensed Embalmer's Statement on Reverse Side)

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

MAY 29 1951

RECEIVED APR 17 1951

SCOTT COUNTY HEALTH CENTER

CO. FILE NO. 451-92

APR 17 1951

NO FEE  
ENCLOSED

APR 17 1951

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.....

working under my personal supervision.

Student Embalmer No.....

Signed Homer L. Ponder

Signed.....  
Student Embalmer

Licensed Embalmer No. 3367

P. O. Address Tilbourn, 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.