

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

26511

STATE FILE NUMBER

FILED SEP 10 1956

Registration District No. 120 Primary Registration District No. 3447 Registrar's No. 77

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| 1. PLACE OF DEATH a. COUNTY Gentry | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Jasper | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Howard Township | | c. CITY OR TOWN Carthage | |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION No. of Albany | | d. STREET ADDRESS (If outside, give location) 0493 | |
| Length of stay in lb 4 wks | | Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> | |

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| 3. NAME OF DECEASED (Type or print) First Minnie Middle Marvie Last Hill | | | 4. DATE OF DEATH Month Sept Day 5 Year 1956 | | | |
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| 5. SEX F | 6. COLOR OR RACE W | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH Sept 3, 1864 | 9. AGE (In years last birthday) 92 | IF UNDER 1 YEAR Months 0 Days 0 | IF UNDER 24 HRS. Hours 0 Min. 0 |
|-----------------|---------------------------|---|--------------------------------------|---|--|--|

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| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife | 10b. KIND OF BUSINESS OR INDUSTRY at home | 11. BIRTHPLACE (City and state or country) Plainfield, Indiana | 12. CITIZEN OF WHAT COUNTRY? U.S. |
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| 13. FATHER'S NAME John W. Pruitt | 14. MOTHER'S MAIDEN NAME Eliza Chadick |
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| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no | 16. SOCIAL SECURITY NO. (If yes, give war or dates of service) | 17. INFORMANT Mrs. Fred Wayman Address Albany, Mo. |
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| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Embolus | | INTERVAL BETWEEN ONSET AND DEATH 6 hours |
| DUE TO (b) Arteriosclerotic cardiovascular disease | | 10 years |
| DUE TO (c) | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Intracapsular fracture left femur | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |

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| 20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/> | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 4221F |
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|----------------------------------|--|---|------------------------------|--------|-------|
| 20c. TIME OF INJURY, a. m. p. m. | 20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | 20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | 20f. CITY, TOWN, OR LOCATION | COUNTY | STATE |
|----------------------------------|--|---|------------------------------|--------|-------|

21. I attended the deceased from **22 Aug 56** to **5 Sept 56** and last saw ^{her}_{mm} alive on **5 Sept 56**
Death occurred at **6:30** p m on the date stated above; and to the best of my knowledge, from the causes stated.

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| 22a. SIGNATURE Frank S. Madison M.D. (Degree or title) | 22b. ADDRESS Grant City, Mo | 22c. DATE SIGNED 9-6-56 |
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| 23a. BURIAL, CREMATION, OR OTHER DISPOSITION burial | 23b. DATE Sept 8, 1956 | 23c. NAME OF CEMETERY OR CREMATORY Park Cemetery | 23d. LOCATION (City, town, or county) (State) Carthage Missouri |
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| 24. FUNERAL DIRECTOR Clifford Smith ADDRESS Albany Mo | 25. DATE RECD. BY LOCAL REG. Sept 6-1956 | 26. REGISTRAR'S SIGNATURE Maudie Williams |
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Health, & Welfare Public Health Service
 S. 300 7-1-56
 Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related. Coroner cannot certify to a death due to natural causes.
 USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

462

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....., Student Embalmer No..... working under my personal supervision..

Student.....
Signature of Student Embalmer

Signed W. H. B. B. B......
Licensed Embalmer No. 73

P. O. Address Albany.....

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.