

FEDERAL DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS JUN 20 1960

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=60-022400

STATE FILE NUMBER

Registration District No. _____ Primary Registration District No. _____ Registrar's No. _____

1. PLACE OF DEATH a. COUNTY Buchanan				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Buchanan			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Joseph			Length of stay in 1b 30 yrs.		c. CITY OR TOWN St. Joseph		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION St. Joseph's Hospital			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) 1111 South 28th St.,		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Warren Middle T. Last Pratt				4. DATE OF DEATH Month June Day 10, Year 1960			
5. SEX Male	6. COLOR OR RACE White	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH Nov. 15, 1889	9. AGE (last birthday) 70	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HR Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Oat Meal Dept.		10b. KIND OF BUSINESS OR INDUSTRY Quaker Oats Co.		11. BIRTHPLACE (City and state or country) Albany, Missouri		12. CITIZEN OF WHAT COUNTRY U.S.A.	
13a. FATHER'S NAME Thomas T. Pratt			13b. MOTHER'S MAIDEN NAME Katherine Setzer			14. NAME OF HUSBAND OR WIFE Hazel May Pratt	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. 491-09-9860		17. INFORMANT Address Hazel M. Pratt, St. Joseph, Missouri			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CANCER PROSTATE METASTATIC						INTERVAL BETWEEN ONSET AND DEATH 4 YRS.	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)						PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> N. <input type="checkbox"/> Unknown	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		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.)			
20c. TIME OF INJURY Hour _____ a.m. _____ p.m. Month, Day, Year _____							
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 JUNE 8-1960 to JUNE 10 1960 and last saw him alive on JUNE 9-1960 Death occurred at 5:55 A. m on the date stated above, and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE (Degree or title) John T. Rogers M.D.				22b. ADDRESS 307 Kildrattach Bldg St Joseph Mo		22c. DATE SIGNED 6/14/60	
22d. BURIAL, CREMATION, REMOVAL (Specify) burial		23a. DATE June 13, 1960		23c. NAME OF CEMETERY OR CREMATORIUM Memorial Park Cemetery		23d. LOCATION (City, town or county) (State) St. Joseph, Missouri	
24. FUNERAL DIRECTOR ADDRESS St. Joseph, Mo.				25. DATE RECD. BY LOCAL REG. June 16, 1960		26. REGISTRAR'S SIGNATURE Wm. Clark Goodell	

DOCUMENT

BY AFFIDAVIT OF J.T. Rogers (Medical Certification)

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by _____
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed *Bill J. Lehman*

Licensed Embalmer No. 467

P. O. Address 57 1/2 St

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.