

DEPARTMENT OF COMMERCE
 BUREAU OF THE CENSUS
FILED JUL 22 1946
 STATE BOARD OF HEALTH OF MISSOURI
 STANDARD CERTIFICATE OF DEATH

24936

State File No. _____
 Registrar's No. 186

Registration District No. 317 Primary Registration District No. 6076

1. PLACE OF DEATH:
 (a) County St. Louis
 (b) City or town Wash. Mo.
(If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution Robert Wood Hospital
(If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution 126 days
(Specify whether)
 In this community 28 years
(years, months or days)

2. USUAL RESIDENCE OF DECEASED:
 (a) State Mo (b) County _____
 (c) City or town St. Louis
(If outside city or town limits, write "RURAL")
 (d) Street No. 3337 1/2 Meramec
(If rural, give location)
 (e) Citizen of foreign country? no (Yes or No)
 If yes, name country _____

3. (a) PRINT FULL NAME PRITCHARD, JESSIE L.
 3. (b) If veteran, name war _____ 3. (c) Social Security No. 490-10-4723

MEDICAL CERTIFICATION
 20. DATE OF DEATH: Month July day 14
 year 1946 hour 10 minute 40 A.M.
 21. I hereby certify that I attended the deceased from 3-8-46
3-8, 1946, to 7-14, 1946;

4. Sex M 5. Color or race W
 6. (a) Single, widowed, married, divorced no
 6. (b) Name of husband or wife 1028 Pritchard
 6. (c) Age of husband or wife if alive 13 years 1885
 7. Birth date of deceased 2 13 1885
(Month) (Day) (Year)

that I last saw him alive on _____, 19____, and that death occurred on the date and hour stated above.

Immediate cause of death Arterial fibrillation
 Due to myocardial infarct (coronary occlusion)
 Due to 138
 Other conditions Arterial Hypertension, Tuberculous Cor. FA.
(Include pregnancy within 3 months of death)

Duration 2 years 3 months
 PHYSICIAN _____
 Underline the cause to which death should be charged statistically. 13

8. AGE: Years 61 Months 5 Days 1
 If less than one day _____ hr. _____ min.

9. Birthplace Fran. Klein County Ill
(City, town, or county) (State or foreign country)

10. Usual occupation nil

11. Industry or business _____

MOTHER FATHER
 12. Name Henry C. Pritchard
 13. Birthplace Illinois Ill
(City, town, or county) (State or foreign country)
 14. Maiden name Lou Wick
 15. Birthplace Illinois Ill
(City, town, or county) (State or foreign country)

16. (a) Informant Robert Wood Hospital Records
 (b) Address Wash. Mo.

17. (a) BURIAL (b) Date thereof July 17 1946
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation NEW ST. MARCUS Cem. Miss. Curtis & Son

18. (a) Signature of funeral director _____
 (b) Address 2906 GRAVOIS

19. (a) 1-16-56 (b) [Signature]
(Date received local registrar) (Registrar's signature)

Major findings: Of operations _____
 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? _____
(Specify type of place) (a) Means of injury

23. Signature Dr. John T. Kabisch (M. D. or other) _____
 Address Robert Wood Hospital, Wash. Mo. Date signed 7/14-46

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

23787

JUL 26 1945

SEP 11 1945

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 Geo J Budd
Licensed Embalmer No. 3989
P. O. Address St. Louis, 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.