DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 16113

FILED MAY 12 1947
Registration District No. 3916

Primary Registration District No. 6133

Registrar's No.

1. PLACE OF DEATH:
(a) County SHANNON
(b) City or town INK, Rural
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: /
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution —
(Specify whether
In this community —
years, months or days)

2. USUAL RESIDENCE OF DECEASED: 10/
(a) State SHANNON (b) County SHANNON
(c) City or town INK, rural 0
(If outside city or town limits, write "RURAL")
(d) Street No. 0
(If rural, give location) 0
(e) Citizen of foreign country? ~~NO~~ NO (Yes or No)
If yes, name country —

3. (a) PRINT FULL NAME MARY Adeline PRATER

3. (b) If veteran, name war —
3. (c) Social Security No. —

4. Sex F /
5. Color or race W
6. (a) Single, widowed, married, divorced W 2/
6. (b) Name of husband or wife —
6. (c) Age of husband or wife if alive — years
7. Birth date of deceased ~~MARCH~~ JUNE (Month) 8 th (Day) 1863 ~~1865~~ (Year)

MEDICAL CERTIFICATION

20. **DATE OF DEATH:** Month 5 day 1
year 1947 hour 12 minute 15 P M.

21. I hereby certify that I attended the deceased from 4-21, 1947, to 5-1, 1947
that I last saw h~~er~~ alive on 4-29 1947
and that death occurred on the date and hour stated above.

Immediate cause of death	Duration
Static Pneumonia /	
Due to Fractured Hip	
Due to	
Other conditions (Include pregnancy within 3 months of death)	

Major findings:
Of operations —
Of autopsy —

A DUPLICATE PHYSICIAN SUPPLEMENTAL INFORMATION REQUESTED

8. AGE: Years	Months	Days	If less than one day
83	10	23	— hr. — min.

9. Birthplace AITON Mo (City, town, or county) — (State or foreign country) 0
10. Usual occupation House wife
11. Industry or business —

MOTHER FATHER
12. Name JAMES BATES /
13. Birthplace KY (City, town, or county) (State or foreign country)
14. Maiden name SARAH JANE YANDLE
15. Birthplace KY (City, town, or county) (State or foreign country) /

16. (a) Informant Mrs Cecil CASWELL
(b) Address St Louis, Mo
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 5-4-1947 (Month) (Day) (Year)
(c) Place: burial or cremation Chrisco Cemetary
18. (a) Signature of funeral director Hobson & Grantham
(b) Address Salem, Mo.
19. (a) 5-6-47 (Date received local registrar) (b) Mabel Rose (Registrar's signature)

22. If death was due to external causes, fill in the following: 10/
(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)
While at work? — (e) Means of injury 0

23. Signature W. T. Eudy M. D (M. D. or other) M.D
Address Eminence Date signed 5-1-47

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Officer No 5,
District File Number 54226
Date Filed 5-10-47

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.....
Edward F. Broyles, Registered Apprentice No. 435
working under my personal supervision.

Signed Max L. Warfel
Licensed Embalmer No. 4170
P. O. Address Salem, Ind.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. May

Registration District No. 336 Primary Registration District No. 6133 Registrar's No.

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

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

3. (a) PRINT FULL NAME Mary A. Prater
3. (b) If veteran, name war
3. (c) Social Security No.

4. Sex F
5. Color or race W
6. (a) Single, widowed, married, divorced Wid
6. (b) Name of husband or wife
6. (c) Age of husband or wife if alive years
7. Birth date of deceased June 8 (Month) (Day) 1864 (Year)
8. AGE: Years 83 Months 10 Days 23 If less than one day hr. min.
9. Birthplace (City, town or county) Mo (State or foreign country)
10. Usual occupation
11. Industry or business
MOTHER
12. Name
13. Birthplace (City, town, or county) (State or foreign country)
FATHER
14. Maiden name
15. Birthplace (City, town, or county) (State or foreign country)
16. (a) Informant
(b) Address
17. (a) (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)
(c) Place: burial or cremation
18. (a) Signature of funeral director
(b) Address
19. (a) (Date received local registrar) (b) (Registrar's signature)

SUPPLEMENTARY 1

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March Day 1 year 1947 hour minute M.
21. I hereby certify that I attended the deceased from , 19 , to , 19 ; that I last saw h alive on , 19 ; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death	
Due to	
Due to	
Other conditions (Include pregnancy within 3 months of death)	
Major findings: Of operations	
Of autopsy	

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify) accident
(b) Date of occurrence 4-21-47
(c) Where did injury occur? Fuk Shannon Mo (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? In Home (Specify type of place)
While at work? (e) Means of injury

23. Signature W-T Eudy MD (M. D. or other) MD
Address Eminence Date signed

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