

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No.

Registration District No. 274

Primary Registration District No. 3052

Registrar's No. 178

1. PLACE OF DEATH:  
(a) County PETTIS  
(b) City or town SEDALIA  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
1219 W. 4th ST.  
(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) 35 YEARS

3. (a) PRINT FULL NAME HARIET FLOYD PRENTISS  
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  
6. (b) Name of husband or wife MELVIN M. 6. (c) Age of husband or wife if alive \_\_\_\_\_ years  
7. Birth date of deceased 1 12 1854  
(Month) (Day) (Year)

8. AGE: Years 89 Months 4 Days 19 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

9. Birthplace BOND CO. ILL  
(City, town, or county) (State or foreign country)

10. Usual occupation HOUSEWIFE

11. Industry or business \_\_\_\_\_

12. Name WM JOHNSON FLOYD  
13. Birthplace IND  
(City, town, or county) (State or foreign country)  
14. Maiden name SARAH EIKE  
15. Birthplace ST. CLAIR CO ILL  
(City, town, or county) (State or foreign country)

16. (a) Informant PAULINE PRENTISS  
(b) Address SEDALIA

17. (a) BURIAL (b) Date thereof 6-3-43  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation CALIFORNIA, MO

18. (a) Signature of funeral director Gillespie

(b) Address SEDALIA, MO

19. (a) 6/3/43 (b) Anna Berger  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:  
(a) State MISSOURI (b) County PETTIS  
(c) City or town ST. 219 W. 4th ST. 80  
(If outside city or town limits, write "RURAL")  
(d) CITY SEDALIA (If rural, give location)  
(e) Citizen of foreign country? no (Yes or No)  
If yes, name country 0

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month JUNE day 1st  
year 1943 hour 2 minute 35 P.M.

21. I hereby certify that I attended the deceased from May 15, 1943, to June 1, 1943;  
that I last saw him alive on June 1st, 1943  
and that death occurred on the date and hour stated above.

Immediate cause of death Cardiac Degeneration

Due to Hypertrophy & Dilatation

Due to \_\_\_\_\_

Other conditions 938  
(Include pregnancy within 3 months of death)

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?

While at work? \_\_\_\_\_ (Specify type of place) (c) Means of injury 0

23. Signature Alfred E. Murre (M. D. or other)  
Address 111 W. 4th St. Sedalia Mo Date signed 6-3-43

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

RECEIVED

District Health Officer No. 8

District File Number

Date Filed 7-2-73

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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

*L. E. Boudreau*

Licensed Embalmer No.

3867

P. O. Address

*See above*

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.