DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED MAR 11 1940

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 5386

Registration District No. 399 — Primary Registration District No. 1002 — Registrar's No. 611

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

1. PLACE OF DEATH:

(a) County: Jackson

(b) City or town: Kansas City (If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: General Hospital #2 (If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 1-20-40-2-5-40 (Specify whether years, months or days)

In this community 40 years

2. USUAL RESIDENCE OF DECEASED:

(a) State: Mo. (b) County: Jackson

(c) City or town: Kansas City (If outside city or town limits, write "RURAL")

(d) Street No.: 2908 Norton (If rural, give location)

(e) If foreign born, how long in U. S. A.? ____ years.

3. (a) PRINT FULL NAME: 660 George Pryor

3. (b) If veteran, name war: No

3. (c) Social Security No.: 495-07-8426

4. Sex: Male

5. Color or race: Negro

6. (a) Single, widowed, married, divorced: Married

6. (b) Name of husband or wife: Lettie Pryor

6. (c) Age of husband or wife if alive: Unknown years

7. Birth date of deceased: 7 (Month) 15 (Day) 1874 (Year)

8. AGE: Years 65 | Months 6 | Days 21 | If less than one day ____ hr. ____ min.

9. Birthplace: Saline County (City, town, or county) Mo. (State or foreign country)

10. Usual occupation: Machine helper

11. Industry or business: Kansas City Star

FATHER
12. Name: Nimrod Pryor
13. Birthplace: W. Virginia (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name: Maria Porter
15. Birthplace: W. Virginia (City, town, or county) (State or foreign country)

16. (a) Informant's own signature: Record Clerk

(b) Address: General Hospital #2

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof: 2-7-1940 (Month) (Day) (Year)

(c) Place: burial or cremation: Highland K.C. Mo.

18. (a) Signature of funeral director: Adkins Bros.

(b) Address: 2000 E. 12th K.C. Mo. 31

19. (a) Feb. 9, 1940 (Date received local registrar) (b) M. McCrone (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 2 day 5 year 40 hour 11 minute 40 P. M.

21. I hereby certify that I attended the deceased from 1-20- 19 40 to 2-5- 19 40 that I last saw him alive on 2-5- 19 40 and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Toxemia	
Due to: Gangrene of Left Foot. (P.O)	
Due to: Diabetes	
Other conditions (Include pregnancy within 3 months of death): 19	
Major findings: Of operations: Leg amputated above knee.	
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)

(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? Means of injury

23. Signature: O. C. Turner (M. D. or other)

Address: General Hospital #2 Date signed: 2-9-40

(Licensed Embalmer's Statement on Reverse Side)

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 Edw G Evans

Licensed Embalmer No. 3836

P. O. Address.....

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

If this body is not embalmed, above space should be left blank.