

No. 2  
-13-40  
17-39  
X23159

Registration District No. 821

Primary Registration District No. 4553

Registrar's No. ....

1. PLACE OF DEATH:  
 (a) County Scott  
 (b) City or town Sikeston, Missouri  
(If outside city or town limits, write "RURAL" and name of township)  
 (c) Name of hospital or institution:  
Sikeston General Hospital  
(If not in hospital or institution, write street number or location)  
 (d) Length of stay: In hospital or ~~home~~ 6 hrs.  
(Specify whether  
 In this community 20 years  
years, months or days)

3. (a) PRINT FULL NAME Eva Mae Pryor  
 3. (b) If veteran, name war None  
 3. (c) Social Security No. None

4. Sex Female 5. Color or race White  
 6. (a) Single, widowed, married, divorced Married  
 6. (b) Name of husband or wife John Pryor  
 6. (c) Age of husband or wife if alive 47 years  
 7. Birth date of deceased Aug. 1 1904  
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	36	4	21	hr. min.

9. Birthplace Clarksville, Tenn.  
(City, town, or county) (State or foreign country)

10. Usual occupation Housewife

11. Industry or business

12. Name R.L. Bryant

13. Birthplace Clarksville, Tenn.  
(City, town, or county) (State or foreign country)

14. Maiden name Igna Maude Cook

15. Birthplace Clarksville, Tenn.  
(City, town, or county) (State or foreign country)

16. (a) Informant John Pryor

(b) Address Sikeston, Mo. Route 3

17. (a) Burial (b) Date thereof 12-23-1940  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Memorial Park Sikeston, Mo.

18. (a) Signature of funeral director [Signature]

(b) Address Sikeston, Missouri

19. (a) 1-8-40 (b) [Signature]  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:  
 (a) State Missouri (b) County New Madrid  
 (c) City or town Rural  
(If outside city or town limits, write "RURAL")  
 (d) Street No. SIKESTON, Mo R#3  
(If rural, give location)  
 (e) If foreign born, how long in U. S. A.? 0 years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month DECEMBER day 22  
 year 1940 hour 3 minute 30 P. M.

21. I hereby certify that I attended the deceased from Dec 21  
 1940, to Dec 22, 1940  
 that I last saw him alive on Dec 22, 1940  
 and that death occurred on the date and hour stated above.

Immediate cause of death  
Chest Partum Hemorrhage

Due to Delivery

Due to

Other conditions  
(Include pregnancy within 3 months of death)  
1440

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?  
742  
(Specify type of place)

While at work? [Signature] (a) Means of injury

23. Signature [Signature] (M. D. or other) 1

Address Sikeston, Mo. Date signed

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

MOTHER FATHER

RECEIVED

District Health Officer No. 2

District File Number 141-79

Date Filed 1/13/46

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 *Harvey J. Hoover*.....

Licensed Embalmer No. 3704

P. O. Address *Si Keaton, 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.**