

FILED AUG 9 1944

Registration District No. _____

Primary Registration District No. 3010

Registrar's No. 220

1. PLACE OF DEATH:

(a) County: Cape

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

(c) Name of hospital or institution: St. Francis Hospital
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 2 Weeks
(Specify whether years, months or days)

In this community 6 Mos. 2 wks.

3. (a) PRINT FULL NAME: Jamie Francis Prodyer

3. (b) If veteran, name war:

3. (c) Social Security No. 487-24-2804

4. Sex: <u>Female</u>	5. Color or race: <u>White</u>	6. (a) Single, widowed, married, divorced: <u>Married</u>
6. (b) Name of husband or wife: <u>J. D. Prodyer</u>	6. (c) Age of husband or wife if alive: <u>61</u> years	
Birth date of deceased: <u>Sept 9 1901</u>	(Month)	(Day) (Year)

8. AGE:

Years: <u>43</u>	Months: <u>6</u>	Days: <u>9</u>	If less than one day: _____ hr. _____ min.
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9. Birthplace: Hawson Springs Ky
(City, town, or county) (State or foreign country)

10. Usual occupation: Wrestling promoter

11. Industry or business: Prodyer Brothers

12. Name: John Franklin

13. Birthplace: Hawson Springs Ky
(City, town, or county) (State or foreign country)

14. Maiden name: no record

15. Birthplace: no record
(City, town, or county) (State or foreign country)

16. (a) Informant: J. D. Prodyer

(b) Address: Chaffee Mo

17. (a) burial (b) Date thereof: 7-6-1944
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation: St. Mary's

18. (a) Signature of funeral director: W. D. Jones

(b) Address: Chaffee Mo

19. (a) 7-10-44 (b) W. D. Jones
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State: Mo (b) County: Scott 100

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

(d) Street No.: 403 N. Main
(If rural, give location)

(e) Citizen of foreign country? no (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 6 year 1944 hour 11:30 minute P M.

21. I hereby certify that I attended the deceased from June 15 1944 July 6 1944

that I last saw h. or alive on _____ and that death occurred on the date and hour stated above.

Immediate cause of death: Post-Operative Complications Duration: 5 days

Due to: Obstruction Peritonitis

Due to: 56 hr

Other conditions (include pregnancy within 3 months of death): _____

Major findings: Hysterectomy Fibrosis - Cervical Erosion

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): _____

(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) (e) Means of injury: _____

23. Signature: W. D. Jones (M. D. or other): _____
Address: Chaffee Mo Date signed: 7-8/44

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

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-4

RECEIVED

District Health Officer No. 4

District File Number 844-4174

Date Filed 8-7-44

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 *C. J. Lovberg*

Licensed Embalmer No. 3810

P. O. Address. Cape Girardeau, 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.