

FILED FEB 24 1947

Registration District No. 25

Primary Registration District No. 6199

Registrar's No. _____

1. PLACE OF DEATH:

(a) County Texas
(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 _____)
In this community _____
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Texas 107
(c) City or town Rural
(If outside city or town limits, write "RURAL")
(d) Street No R.F.D. # 1, Mt. Grove, Mo. 1
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME Rose Evelyn Pryer

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

4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife William A. Pryer 6. (c) Age of husband or wife if alive 35 years

7. Birth date of deceased Sept. 12 1916
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>30</u>	<u>5</u>	<u>0</u>	hr. _____ min.

9. Birthplace Lindsay Calif.
(City, town, or county) (State or foreign country)

10. Usual occupation Housewife

11. Industry or business _____

MOTHER FATHER { 12. Name James C. Pope
13. Birthplace Douglas County Missouri
(City, town, or county) (State or foreign country)

{ 14. Maiden name Stella Ballew
15. Birthplace Wright County Missouri
(City, town, or county) (State or foreign country)

16. (a) Informant William A. Pryer
(b) Address Mt. Grove, Mo.

17. (a) Burial (b) Date thereof 2 16/1947
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Hill Crest Cemetery

18. (a) Signature of funeral director Thomas A. Badden

(b) Address Box 136, Norwood, Missouri

19. (a) _____ (b) Haywell Cunningham
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month February day 12
year 1947 hour 10 minute 45 PM.

21. I hereby certify that I attended the deceased from Oct. 1 - 1946 to 2-12-1947
that I last saw him alive on 2-10-1947
and that death occurred on the date and hour stated above.

Immediate cause of death Pulmonary Tuberculosis
Duration _____

Due to _____

Due to _____

Other conditions _____
(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) (e) Means of injury 0

23. Signature P. W. Deaney (M. D. or other) _____

Address Mt. Grove Mo. Date signed 2-14-47

PHYSICIAN

Underline the cause to which death should be charged statistically.

325

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 Thomas A. Hauldrie
Licensed Embalmer No. 4317
P. O. Address Box 136 - Newwood,

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

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

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No.

Registration District No. 354

Primary Registration District No. 6199

Registrar's No.

1. PLACE OF DEATH:

(a) County Texas
(b) City or town Union 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 _____ (Specify whether _____)
years, months or days)

3. (a) PRINT FULL NAME Rose E. Pryer

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 m

6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____

7. Birth date of deceased Sept 12 (Month) (Day) (Year)

8. AGE: Years 30 Months 5 Days _____ If less than one day _____ hr. _____ min.

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

MOTHER FATHER

10. Usual occupation _____

11. Industry or business _____

12. Name _____

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

14. Maiden name _____

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

16. (a) Informant _____

(b) Address _____

17. (a) _____ (b) Date thereof _____ (Month) (Day) (Year)
(Burial, cremation, or removal)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) _____ (b) Gaynell Cunningham (Date received local registrar) (Registrar's signature)

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 _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July Year 1942 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____ to _____

that I last saw him _____ alive on _____ and that death occurred on the date and hour stated above.
Immediate cause of death _____

Duration

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) _____

(b) Date of occurrence _____

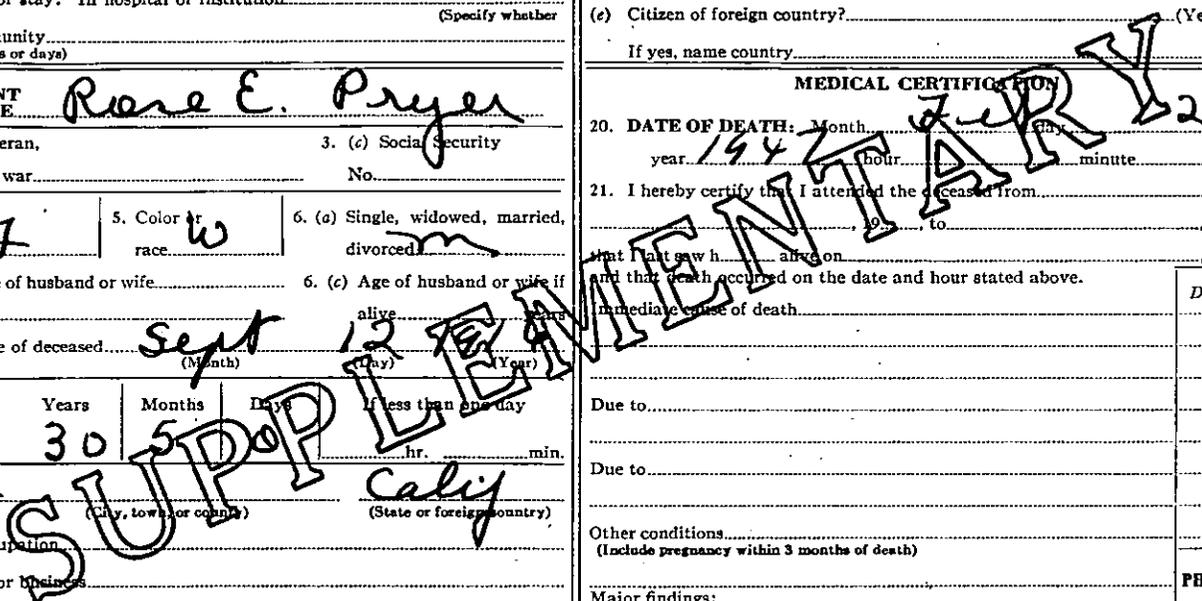
(c) Where did injury occur? _____ (City or town) (County) (State)

(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 _____ (M. D. or other) _____

Address _____ Date signed _____



S-7609