

MISSOURI DIVISION OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **26906**

FILED SEP 4 1948
Registration District No. **2883**

Primary Registration District No. **5655**

Registrar's No. **399**

1. PLACE OF DEATH:

(a) County **Lawrence**
(b) City or town **Mt. Vernon**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
Missouri State Sanatorium
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **49 days** (Specify whether years, months or days)
In this community **49 days**

3: (a) PRINT FULL NAME **Le Roy D. Pryor**

3. (b) If veteran, name war **No** 3. (c) Social Security No. **488-14-2849**

4. Sex **Male** 5. Color or race **White**
6. (a) Single, widowed, married, divorced **Married**
6. (b) Name of husband or wife **Lois E. Pryor** 6. (c) Age of husband or wife if alive **42** years
7. Birth date of deceased **Oct. 7 1881**
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
66 10 16 hr. min.

9. Birthplace **St. Joseph, Missouri**
(City, town, or county) (State or foreign country)

10. Usual occupation **Painter**

11. Industry or business

MOTHER FATHER
12. Name **James D. Pryor**
13. Birthplace **Unknown** **9**
(City, town, or county) (State or foreign country)
14. Maiden name **Julia Lewis Pryor**
15. Birthplace **Unknown** **9**
(City, town, or county) (State or foreign country)

16. (a) Informant **E. McMichael, Record Clerk**
(b) Address **Mo. State San. Mt. Vernon, Mo.**
17. (a) **Burial** (b) Date thereof **8-28-48**
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation **Ashland Cemetery**

18. (a) Signature of funeral director **Thomas Funeral Home**
(b) Address **St. Joseph, Mo.**
19. (a) **Aug 28, 1948** (b) **Carl Kendrick**
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **Buchanan**
(c) City or town **1507 - 4th Ave. St. Joseph**
(If outside city or town limits, write "RURAL")
(d) Street No. (If rural, give location)
(e) Citizen of foreign country? **No** (Yes or No)
If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **August** day **28**
year **1948** hour **2:30** minute **A** M.

21. I hereby certify that I attended the deceased from **July 5**, 19 **48** to **August 23**, 19 **48**
that I last saw h. **im** alive on **August 23**, 19 **48**
and that death occurred on the date and hour stated above.

Immediate cause of death **Bronchial stenosis on the left** Duration

Due to **Cancer, with pneumonitis on the left. (Pulmonary) Abt. 15 mos.**

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

Major findings:
Of operations
Of autopsy **Same as above**
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 **O. A. Braucher** (M.D. or other)
Address **Mt. Vernon, Missouri** Date signed **8-23-48**

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

RECEIVED

District Health Officer No. 6;

District File Number: 948-977

Date Filed: SEP 2 1948

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: *John Roy Stamer*

Licensed Embalmer No. 2435

P. O. Address: *St. Joseph*

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.