

FILED AUG 5 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

24537

State File No.

BIRTH NO. 124 REG. DIST. NO. 316 PRIMARY REG. DIST. NO. 6074 Registrar's No. 276

1. PLACE OF DEATH a. COUNTY <u>St. Francois</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY <u>St. Francois</u>	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Desloge, Mo.</u>		c. LENGTH OF STAY (in this place) <u>5 weeks</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>602 Chestnut</u>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>R. Route 2 Farmington, Mo.</u>	
		d. STREET ADDRESS (If rural, give location) <u>Near Eather, Mo.</u>	

3. NAME OF DECEASED (Type or Print) a. (First) <u>Wilce</u> b. (Middle) <u>M.</u> c. (Last) <u>Prvor</u>			4. DATE OF DEATH (Month) (Day) (Year) <u>July 25, 1949</u>		
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>widowed</u>	8. DATE OF BIRTH <u>Nov. 28, 1877</u>	9. AGE (In years last birthday) <u>73</u>	IF UNDER 1 YEAR Months <u>7</u> Days <u>27</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Machinist</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Lead Co.</u>	11. BIRTHPLACE (State or foreign country) <u>Black River, Mo.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U S</u>

13a. FATHER'S NAME <u>Monroe Prvor</u>	13b. MOTHER'S MAIDEN NAME <u>Polley Loftis</u>	14. NAME OF HUSBAND OR WIFE <u>Nora Melton, Prvor</u>
--	--	---

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>	16. SOCIAL SECURITY NO. <u>none</u>	17. INFORMANT'S SIGNATURE OR NAME: <u>Mrs. Myra Walton</u> ADDRESS <u>602 Chestnut, st.</u>
---	-------------------------------------	---

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Arterio sclerotic cardiovascular</u>		INTERVAL BETWEEN ONSET AND DEATH <u>4 1/2 X</u>
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>lesion & decompensation of heart</u> DUE TO (c)		
	II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
------------------------	----------------------------------	--

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
--	--	---

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21e. INJURY OCCURRED WHILE AT <input type="checkbox"/> WORK NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?
--	--	----------------------------

22. I hereby certify that I attended the deceased from April 19 49, to July 25, 19 49, that I last saw the deceased alive on July 25, 19 49, and that death occurred at 10 39 m., from the causes and on the date stated above.

23a. SIGNATURE <u>J. C. Foster</u> (Degree or title) <u>M.D.</u>	23b. ADDRESS <u>Desloge Mo</u>	23c. DATE SIGNED <u>7-27-49</u>
--	--------------------------------	---------------------------------

24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	24b. DATE <u>July 27, 1949</u>	24c. NAME OF CEMETERY OR CREMATORY <u>St. Fran. Mem. Pk.</u>	24d. LOCATION (City, town, or county) (State) <u>Near Desloge, Mo.</u>
---	--------------------------------	--	--

DATE REC'D BY LOCAL REG. <u>July 28, 1949</u>	REGISTRAR'S SIGNATURE <u>Eather</u>	25. FUNERAL DIRECTOR'S SIGNATURE <u>Rudolph A. Z. Hayes & Son</u> ADDRESS <u>Desloge Mo.</u>
---	-------------------------------------	--

WRITE PLAINLY--USING UNFADING BLACK INK--MAKE A PERMANENT RECORD

RECEIVED 8-1-49

District Health Officer No. 4

District File Number 849-10

Date Filed _____

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 _____

Student Embalmer No. _____

working under my personal supervision.

Student
Student Embalmer

Signed B. T. Boyer

Licensed Embalmer No. 3660

P. O. Address Deluge, 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.