

FILED JUL 6 1950

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. 19715

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. 71 PRIMARY REG. DIST. NO. 3012 Registrar's No. 80

1. PLACE OF DEATH a. COUNTY <u>Clay</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY <u>Clay</u>	
b. CITY (If outside corporate limits, write RURAL and give township) <u>Excelsior Springs</u>		c. CITY (If outside corporate limits, write RURAL and give township) <u>Excelsior Springs</u>	
c. LENGTH OF STAY (in this place) <u>14 years</u>		d. STREET ADDRESS (If rural, give location) <u>216 South Kimball</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>216 South Kimball</u>			

3. NAME OF DECEASED (Type or Print) a. (First) <u>ROSA</u> b. (Middle) <u>LENA</u> c. (Last) <u>PRICHARD</u>	4. DATE OF DEATH (Month) (Day) (Year) <u>June 2, 1950</u>
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5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>Oct. 21, 1877</u>	9. AGE (In years last birthday) <u>72</u>	IF UNDER 1 YEAR Months <u>7</u>	IF UNDER 11 HRS. Days <u>11</u>	Hours <u>11</u>	Min. <u></u>
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>at home</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>none</u>	11. BIRTHPLACE (State or foreign country) <u>Missouri</u>	12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
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13a. FATHER'S NAME <u>Thomas Beer</u>	13b. MOTHER'S MAIDEN NAME <u>Medie Rose</u>	14. NAME OF HUSBAND OR WIFE <u>Ben Prichard</u>
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>	16. SOCIAL SECURITY NO. <u>None</u>	17. INFORMANT'S SIGNATURE OR NAME <u>Edna Smith</u>	ADDRESS <u>216 South Kimball Excelsior Springs Mo.</u>
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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>Cerebral thrombosis</u>		INTERVAL BETWEEN ONSET AND DEATH <u>6 1/2 days</u>  <u>years -</u>
	ANTECEDENT CAUSES Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Typhus</u>		
	DUE TO (c) DUE TO (c) <u>Chronic fibrotic and gastric cystic</u>		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>Chronic fibrotic and gastric cystic</u>		332X	

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>
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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)
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR
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22. I hereby certify that I attended the deceased from 12/29, 1949, to 6-2, 1950, that I last saw the deceased alive on 4-2, 1950, and that death occurred at 6:30 p.m., from the causes and on the date stated above.

23a. SIGNATURE <u>Reginald Robinson M.D.</u>	(Degree or title)	23b. ADDRESS <u>Excelsior Springs Mo</u>	23c. DATE SIGNED <u>6/5/50</u>
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24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE <u>6/4/50</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Lawson</u>	24d. LOCATION (City, town, or county) (State) <u>Lawson Mo.</u>
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DATE REC'D BY LOCAL REG. <u>6/4/50</u>	REGISTRAR'S SIGNATURE <u>Caroline Hutchings</u>	25. FUNERAL DIRECTOR'S SIGNATURE <u>Clayton Prichard</u>	ADDRESS <u>Excelsior Springs Mo.</u>
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

RECEIVED

JUN 28

District Health Officer No. 8,

District File Number .....

Date Filed 6-29-50

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 Lindell K. Jarman

Licensed Embalmer No. 4589

P. O. Address Excelsior Springs, 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.