

No. 300
10.48

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

37964

NOV 25 1952

State File No.

BIRTH NO. _____ REG. DIST. NO. 59 PRIMARY REG. DIST. NO. 5218 Registrar's No. 164

199
3

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

1. PLACE OF DEATH a. COUNTY <u>Cass</u>		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before death.) a. STATE <u>Iowa</u> b. COUNTY <u>Pottawattamie</u>	
b. CITY (If outside corporate limits, write RURAL and give township) <u>Rural Big Creek Twp.</u>	c. LENGTH OF STAY (in this place) <u>5 min</u>	c. CITY (If outside corporate limits, write RURAL and give township) <u>Rural Valley Twp. 8140</u>	
d. FULL NAME OF (If not a hospital or institution, give street address or location) HOSPITAL OR INSTITUTION <u>1 1/2 mi N of Hannibal on 71 By Pass</u>		d. STREET ADDRESS (If rural, give location) <u>1 mile S of Hancock</u>	

3. NAME OF DECEASED (Type or Print) a. (First) <u>HAROLD</u> b. (Middle) <u>IVAN</u> c. (Last) <u>PRIEST</u>	4. DATE OF DEATH (Month) (Day) (Year) <u>NOV. 16 1952</u>
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5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>	8. DATE OF BIRTH <u>Jan 8 1911</u>	9. AGE (in years last birthday) <u>41</u>	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 2 HRS. Hours Min.
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10a. USUAL OCCUPATION (Give kind of work during most of working life, even if retired) <u>Farmer</u>	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <u>Hancock Iowa</u>	12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
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13a. FATHER'S NAME <u>Harry Priest</u>	13b. MOTHER'S MAIDEN NAME <u>Anna E. Buck</u>	14. NAME OF HUSBAND OR WIFE <u>Letha Priest</u>
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give branch and type of service) <u>yes World War II</u>	16. SOCIAL SECURITY NO.	17. INFORMANT'S SIGNATURE OR NAME <u>Frank Pellier Carson Jr</u>	ADDRESS <u>Carson 2a</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>TRACTURE, COMMINATED, SKULL</u>		INTERVAL BETWEEN ONSET AND DEATH <u>Immediate</u>
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____		
	II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>TRACTURE BOTH FOREARMS</u> <u>TRACTURE L. Tibia Upper 1/3</u>		

19a. DATE OF OPERATION <u>Nov 16 1952</u>	19b. MAJOR FINDINGS OF OPERATION <u>None</u>	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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21a. ACCIDENT SUICIDE HOMICIDE (Specify) <u>Accident</u>	21b. PLACE OF INJURY (e.g., to or about home, farm, factory, street, office bldg., etc.) <u>Highway</u>	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) <u>11 miles N/HARRISONVILLE CASS MO</u>
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour) <u>Nov. 16 1952 12:30 A</u>	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	21f. HOW DID INJURY OCCUR? <u>COLLISION OF TWO CARS</u>
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22. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at 12:30 A m., from the causes and on the date stated above.

23a. SIGNATURE (Name or title) <u>Dr. J. J. Corovic M.D.</u>	23b. ADDRESS <u>HARRISONVILLE, MO</u>	23c. DATE SIGNED <u>Nov. 16 1952</u>
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24a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>	24b. DATE <u>Nov 15 1952</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Henderson Cemetery</u>	24d. LOCATION (City, town, or county) (State) <u>Hannibal Iowa</u>
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DATE REC'D BY LOCAL REG. <u>Nov 16 1952</u>	REGISTRAR'S SIGNATURE <u>Dora Bernard</u>	FUNERAL DIRECTOR'S SIGNATURE <u>Bunenburgis</u>	ADDRESS <u>Hannibal Mo</u>
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JAN 16 1959

JAN 2 1959

RECEIVED
NOV 22
CASS COUNTY
HEALTH DEPARTMENT

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 Ernest W. Remmenbayer

Licensed Embalmer No. 3368

P. O. Address Harrisonville 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.