

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

FILED NOV 3 - 1954

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

33461

State File No. ....

BIRTH NO. 14962-54 REG. DIST. NO. 100 PRIMARY REG. DIST. NO. 5387 Registrar's No. 77

1. PLACE OF DEATH a. COUNTY <u>Dent</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY <u>Dent</u>	
b. CITY (If outside corporate limits, write RURAL and give OR TOWN <u>Rural Osage</u> )		c. CITY OR TOWN <u>Boss</u>	d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
c. LENGTH OF STAY (In this place) <u>8 mos</u>		e. STREET ADDRESS (If rural, give location) <u>Osage typ</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>X</u>			

3. NAME OF DECEASED (Type or Print)	a. (First) <u>Gloria</u>	b. (Middle) <u>Jane</u>	c. (Last) <u>Pryor</u>	4. DATE OF DEATH (Month) (Day) (Year) <u>10-26-54</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>infant</u>	8. DATE OF BIRTH <u>Feb 25 1954</u>	9. AGE (In years last birthday) <u>8</u>	IF UNDER 1 YEAR Months <u>8</u> Days	IF UNDER 24 HRS. Hours <u></u> Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>infant</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>-</u>	11. BIRTHPLACE (City and State or Foreign Country) <u>Dent Co Mo</u>	12. CITIZEN OF WHAT COUNTRY? <u>US</u>
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13a. FATHER'S NAME <u>Otis Pryor</u>	13b. MOTHER'S MAIDEN NAME <u>Dorothy Denton</u>	14. NAME OF HUSBAND OR WIFE <u>X</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>X</u>	17. INFORMANT'S SIGNATURE OR NAME <u>Otis Pryor</u>	ADDRESS <u>Boss 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, asphyxia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH <u>10 days!</u>
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>broncho pneumonia</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.			

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION <u>491 X</u>	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" 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) (m.)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	21f. HOW DID INJURY OCCUR?
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22. I hereby certify that I attended the deceased from 2-25, 1954, to 10-26, 1954, that I last saw the deceased alive on uncertain, 19    , and that death occurred at 5:45A m., from the causes and on the date stated above.

23a. SIGNATURE <u>Joy S. LeDent</u> (Degree or title) <u>MD.</u>	23b. ADDRESS <u>Salem Mo.</u>	23c. DATE SIGNED <u>10-26-54</u>
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24a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>	24b. DATE <u>10-28-54</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Boss Cem</u>	24d. LOCATION (City, town, or county) (State) <u>Boss Mo</u>
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DATE REC'D BY LOCAL REG. <u>10-26-54</u>	REGISTRAR'S SIGNATURE <u>M. M. Hart, M.D. by M.E.!</u>	25. FUNERAL DIRECTOR'S SIGNATURE <u>[Signature]</u>	ADDRESS <u>Salem Mo</u>
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**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.....  
Signature of Student Embalmer

Signed.....  
*Carl H. Spence*

Licensed Embalmer No. *23*

P. O. Address *Salina*

Note: The above **MUST BE SIGNED BY THE LICENSED EMBALMER** in his **OWN HANDWRITING**. (to comply with the above constitutes grounds for revocation of license).  
If embalmed by a **STUDENT**, he also shall sign in his **OWN** handwriting.  
If this body is not embalmed, fact should be so stated above.