

Section, Chapter, etc. must use only standard nomenclature in Part 18. No symptoms will be listed. All diseases in Part I must be causally related. Coroner cannot certify to a death due to natural causes.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

38767

STATE FILE NUMBER

FILED NOV 28 1956

61439-57

Registration District No. 209

Primary Registration District No. 3043

Registrar's No. 409

1. PLACE OF DEATH a. COUNTY <b>Marion Co.</b>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>Audrain</b>		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Hannibal</b>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <b>Vandalia</b>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>St. Elizabeth</b>		Length of stay in lb <b>1 day</b>	d. STREET ADDRESS <b>1011 S. Maple Ave.</b>		(If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>Wanda</b> Middle <b>Jean</b> Last <b>Prior</b>			4. DATE OF DEATH Month <b>Sept.</b> Day <b>20</b> Year <b>1956</b>		
5. SEX <b>F</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Sept. 19, 1956</b>		9. AGE (In years last birthday) IF UNDER 1 YEAR Months <b>1</b> Days <b>1</b> Hours <b></b> Min. <b></b> IF UNDER 24 HRS. Hours <b></b> Min. <b></b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) <b>Hannibal, Mo.</b>	
13. FATHER'S NAME <b>Louis Prior</b>			14. MOTHER'S MAIDEN NAME <b>Mary Snyder</b>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Address <b>Mary Prior, Rte. 2, Vandalia, Mo.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral hemorrhage</b> DUE TO (b) <b>hemorrhage into both lungs</b> DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					INTERVAL BETWEEN ONSET AND DEATH <b>1 day</b> <b>1 1 1</b>
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Birth injury. Rapid labor</b>		
20c. TIME OF INJURY. Hour - Month, Day, Year a. m. p. m.			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION COUNTY STATE	
21. I attended the deceased from <b>Sept 19 1956</b> to <b>Sept 20 1956</b> and last saw her alive on <b>Sept 20, 1956</b> Death occurred by <b>5:00 PM</b> m on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE <b>Ernest L. Kerne MD</b>			22b. ADDRESS <b>Vandalia Mo</b>		22c. DATE SIGNED <b>11/16/56</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>9/20/56</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Vandalia Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Vandalia Mo.</b>
24. FUNERAL DIRECTOR ADDRESS <b>H. B. Waters Vandalia, Mo</b>			25. DATE RECD. BY LOCAL REG. <b>11-23-56</b>		26. REGISTRAR'S SIGNATURE <b>Dr. Em. Lucke by W. C. Fisher</b>

RECEIVED NOV 26 1956  
MARION CO. HEALTH DEPT.  
DATE FILED NOV 26-1956

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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 *William B. Wate*

Licensed Embalmer No. *410*

P. O. Address *Kendalia*

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.