XC 502 470

FILED AUG 26 1957

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

29910
STATE FILE NUMBER

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 7101

1. PLACE OF DEATH
a. COUNTY
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN 915 N Grand St. Louis, Mo. Inside Limits Yes X No ☐
c. FULL NAME OF HOSPITAL OR INSTITUTION V. A. HOSPITAL Length of stay in Ib 24 Days

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE ILLINOIS b. COUNTY Marion
c. CITY OR TOWN CARTTER 8128 Inside Limits Yes X No ☐
d. STREET ADDRESS 32 (If outside, give location) Reside on Farm Yes ☐ No X

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3. NAME OF DECEASED (Type or print) First SAMUEL Middle B Last PROSISE
4. DATE OF DEATH Month Day Year 7/29/57
5. SEX MALE
6. COLOR OR RACE WHITE
7. MARRIED X NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH 5/28/87
9. AGE (In years last birthday) 70 yrs IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer
10b. KIND OF BUSINESS OR INDUSTRY Farming
11. BIRTHPLACE (City and state or country) Salem, Illinois
12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME William H. Prosise
14. MOTHER'S MAIDEN NAME Nancy Evans
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes, give war or dates of service) WW-1
16. SOCIAL SECURITY NO. Unknown
17. INFORMANT Address V. A. HOSPITAL RECORDS ST. LOUIS, MO.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CHRONIC MYELOGENOUS LEUKEMIA — — — INTERVAL BETWEEN ONSET AND DEATH UNK.
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) — — 204.1
DUE TO (c) — —
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) — — 19. WAS AUTOPSY PERFORMED? YES X NO ☐
20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐ NONE
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) — — —
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year — — —
20d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
20f. CITY, TOWN, OR LOCATION COUNTY STATE
VA
21. I attended the deceased from 7/5/57, to 7/29/57 and last saw ~~XXX~~ him alive on 7/29/57
Death occurred at 6:50 a. m. on the date stated above; and to the best of my knowledge, from the causes stated.
22a. SIGNATURE (Degree or title) M.D.
22b. ADDRESS VAHOSPITAL ST. LOUIS, MISSOURI
22c. DATE SIGNED 7/29/57

23a. BURIAL, CREMATION, REMOVAL (Specify) Removal
23b. DATE 7-29-57
23c. NAME OF CEMETERY OR CREMATORY J. T. KAMINSKAS, M. D.
23d. LOCATION (City, town, or county) (State) Kell, Illinois.
24. FUNERAL DIRECTOR ADDRESS Albert H. Hoppe, 4700 Washington Blvd.
25. DATE RECD. BY LOCAL REG. JUL 30 57
26. REGISTRAR'S SIGNATURE J. Carl Smith M.D.

(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

diseases in Part I must be casually related. Coroner cannot certify to a death due to natural causes.

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was

by me, or by ....., Student Embalmer No.....

working under my personal supervision.

Student.....
Signature of Student Embalmer

Signed Elmo R Gad

Licensed Embalmer No. 4

P. O. Address St Lo

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.