

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

36647

STATE FILE NUMBER

FILED OCT 25 1957

Registration District No. 209 Primary Registration District No. 3043 Registrar's No. 399

Health,
& Welfare
Public
Service

S. 300
v. 1-56

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

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

1. PLACE OF DEATH a. COUNTY <u>Marion</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Ill.</u> b. COUNTY <u>Pike</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Hannibal</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN <u>Hull</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>St. Elizabeth Hospital</u> Length of stay in lb <u>5 wks</u>		d. STREET ADDRESS (If outside, give location) <u>Hull</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Emmet Pryor</u> First Middle Last		4. DATE OF DEATH <u>10 - 12 - 1957</u> Month Day Year	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan 6, 1896</u>
9. AGE (In years last birthday) <u>61</u>		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Section Foreman</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>CB&Q R.R.</u>	11. BIRTHPLACE (City and state or country) <u>Rockport, Ill.</u>
12. CITIZEN OF WHAT COUNTRY? <u>US</u>		13. FATHER'S NAME <u>Charles Pryor</u>	
14. MOTHER'S MAIDEN NAME <u>Hattie McMullen</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> (If yes, give war or dates of service) <u>WW No. 1</u>	
16. SOCIAL SECURITY NO. <u>WW No. 1</u>		17. INFORMANT <u>Mrs. Grace Pryor Hull, Ill.</u> Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Ca of Rt Kidney with metastasis</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>180X</u>			INTERVAL BETWEEN ONSET AND DEATH <u>6 months</u>
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		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.)		20c. TIME OF INJURY Hour Month, Day, Year a. m. p. m.	
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		20g. COUNTY STATE	
21. I attended the deceased from <u>Jan 15, 1957 - 12 5 57</u> and last saw him alive on <u>10-12-57</u> Death occurred at <u>Hannibal, Mo.</u> on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <u>Ralph Clark M.D.</u>		22b. ADDRESS <u>Hannibal, Mo.</u>	
22c. DATE SIGNED <u>10-14-57</u>		23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	
23b. DATE <u>10-15-1957</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Kinderhook Cemetery</u>	
23d. LOCATION (City, town, or county) <u>Kinderhook, Ill.</u>		23e. (State)	
24. FUNERAL DIRECTOR <u>Ralph Clark Funeral Home Hannibal, Mo.</u> ADDRESS		25. DATE RECD. BY LOCAL REG. <u>10/16/57</u>	
26. REGISTRAR'S SIGNATURE <u>Em Luke Byrd</u>		26. REGISTRAR'S SIGNATURE	

(Licensed Embalmer's Statement on Reverse Side)

am
129-0

RECEIVED OCT 22 1957
MARION CO. HEALTH DEPT.
DATE FILED OCT 22 1957

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.....

Licensed Embalmer No...4217

P. O. Address...Hannibal,...

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.