

t. Health,
, & Welfare
S. Public
th Service

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-032287

STATE FILE NUMBER

FILED SEP 24 1958

Registration District No. 110 Primary Registration District No. 4182 Registrar's No. 49

S. 300
v. 1-57

1. PLACE OF DEATH a. COUNTY Franklin		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Franklin	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN New Haven		c. CITY OR TOWN New Haven	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION		d. STREET ADDRESS (If outside, give location)	
Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
Length of stay in lb		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First Middle Last OSCAR DANIEL PRYOR			4. DATE OF DEATH Month Day Year Sept. 21 1958		
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5. SEX Male		6. COLOR OR RACE Colored		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH June 18, 1889		9. AGE (In years last birthday) 69		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.	
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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) Holstein Mo.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
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13a. FATHER'S NAME John Pryor		13b. MOTHER'S MAIDEN NAME Martha Johnson		14. NAME OF HUSBAND OR WIFE Alice Pryor	
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15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes World War #1		16. SOCIAL SECURITY NO. 493-40-8728		17. INFORMANT Address Mrs. Oscar Pryor New Haven Mo.	
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Metastatic carcinoma of liver and lungs			INTERVAL BETWEEN ONSET AND DEATH 6 mo.		
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) Carcinoma of sigmoid colon			1 yr.		
DUE TO (c) 1533			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)					

20a. ACCIDENT SUICIDE HOMICIDE <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)		
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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 COUNTY STATE		
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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		
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21. I attended the deceased from June 29, 1958 to Sept. 21, 1958 and last saw ^{him} alive on Sept. 20, 1958 Death occurred at 8:30 A. m on the date stated above; and to the best of my knowledge, from the causes stated.					
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22a. SIGNATURE (Degree or title) [Signature] D.O.			22b. ADDRESS New Haven, Missouri			22c. DATE SIGNED 9/22/58		
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23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 9-23-1958		23c. NAME OF CEMETERY OR CREMATORY Nortmann Cemetery		23d. LOCATION (City, town, or county) (State) New Haven Mo.	
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24. FUNERAL DIRECTOR ADDRESS L. C. Fertig & Son New Haven Mo.			25. DATE RECD. BY LOCAL REG. Sept. 23-1958		26. REGISTRAR'S SIGNATURE [Signature]		
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(Licensed Embalmer's Statement on Reverse Side)

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE
MEDICAL CERTIFICATION

8684 8 130

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 me....., Student Embalmer No. working under my personal supervision.

Student
Signature of Student Embalmer

Signed Carl C. Leiter.....

Licensed Embalmer No. 3685.....

P. O. Address New Haven, Ct......

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.