

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

59-005816

STATE FILE NUMBER

950

FILED MAR 11 1959

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 950

300

-57

1. PLACE OF DEATH a. COUNTY <b>JACKSON</b>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>Gentry</b>			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>KANSAS CITY MISSOURI</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <b>McFall</b>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>OSTEOPATHIC HOSP</b>		Length of stay in 1b <b>11 days</b>	d. STREET ADDRESS (If outside, give location) <b>Rt. # 2</b>		Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>AIMA</b> Middle <b>L</b> Last <b>PRYOR</b>			4. DATE OF DEATH Month <b>2</b> Day <b>18</b> Year <b>59</b>			
5. SEX <b>F</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>July 18, 1882</b>	9. AGE (In years last birthday) <b>76</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Housekeeper</b>		11. BIRTHPLACE (City and state or country) <b>Gentry County, Mo.</b>		
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13a. FATHER'S NAME <b>John Elam</b>		13b. MOTHER'S MAIDEN NAME <b>Hattie M. Boise</b>		
14. NAME OF HUSBAND OR WIFE <b>John Maynard Pryor</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>Unknown</b>		
17. INFORMANT <b>John Maynard Pryor, Rt. # 2, McFall 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>Acute left heart failure</b>		INTERVAL BETWEEN ONSET AND DEATH <b>days</b>		
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) <b>Aortic stenosis</b>		DUE TO (c) <b>Coronary artery disease</b>		<b>0 F</b> years		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>1. Fracture of the head of left femur. 2. Adynamic ileus</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" 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 _____ a.m. _____ p.m. Month, Day, Year _____						
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>2/7/59</b> , to <b>2/18/59</b> and last saw her alive on <b>2/18/59</b> Death occurred at <b>9:50 A.M.</b> m on the date stated above; and to the best of my knowledge, from the causes stated.						
22a. SIGNATURE (Degree or title) <b>Milton S. Steinberg D.O.</b>			22b. ADDRESS <b>926 E. 11<sup>th</sup> St. Kansas City, Mo.</b>		22c. DATE SIGNED <b>2/18/59</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>2-20-1959</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Fairview Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>McFall, Mo.</b>	
24. FUNERAL DIRECTOR <b>Louis Quert</b>		ADDRESS <b>Pattonsburg, Mo.</b>		25. DATE RECD. BY LOCAL REG. <b>2-19-59</b>	26. REGISTRAR'S SIGNATURE <b>Neva Marshall</b>	

Milton S. Steinberg ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

All diseases in Part I must be causally related.

MS SEP 18 1953

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 *Louis Forest* .....

Licensed Embalmer No. *4096* .....  
P. O. Address *Pattonburg* .....

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.