

R DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH
FILED VS NOV 7 1960

-60-037305
 STATE FILE NUMBER

Registration District No. 1 Primary Registration District No. 3000 Registrar's No. 317

1. PLACE OF DEATH a. COUNTY ADAIR				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo. b. COUNTY Adair				
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Kirksville,		Length of stay in 1b 7 yrs		c. CITY OR TOWN Kirksville		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		
c. FULL NAME OF (if NOT in hospital, give location) HOSPITAL OR INSTITUTION 704 W. Gardner			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) 704 W. Gardner		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First WALTER Middle LEE Last PRYOR				4. DATE OF DEATH Month Oct. Day 29 Year 1960				
5. SEX Male	6. COLOR OR RACE White	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH 10/18/82	9. AGE (last birthday) 78	IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/>	IF UNDER 24 HR Hours <input type="checkbox"/> Min. <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) retired farmer			10b. KIND OF BUSINESS OR INDUSTRY Farming		11. BIRTHPLACE (City and state or country) Schuyler Co., Mo.		12. CITIZEN OF WHAT COUNTRY U S	
13a. FATHER'S NAME John C. Pryor			13b. MOTHER'S MAIDEN NAME Sintha Robinson			14. NAME OF HUSBAND OR WIFE Ada Miles Pryor		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) No			16. SOCIAL SECURITY NO. 492-28-2501		17. INFORMANT Address Ada M. Pryor, Kirksville, Mo.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:							INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (a) Massive Cerebral Hemorrhage							1 1/2 hrs	
DUE TO (b) Hypertension							years	
DUE TO (c) Arteriosclerosis							years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)						PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> N: <input type="checkbox"/> Unknown		
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 Aug. 1957 to Oct. 1960 and last saw him alive on Aug. 21 1960 Death occurred at 2:10 a.m. on the date stated above, and to the best of my knowledge, from the causes stated.								
22a. SIGNATURE <i>[Signature]</i> (Degree or title)				22b. ADDRESS 401 S. Elson, Kirksville, Mo.			22c. DATE SIGNED 10/29/60	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 10/31/60	23c. NAME OF CEMETERY OR CREMATION Winnigan		23d. LOCATION (City, town, or county) (State) Winnigan, Sullivan, Mo.			
24. FUNERAL DIRECTOR <i>[Signature]</i> ADDRESS Foster Memorial Home, Kirksville, Mo.				25. DATE RECD. BY LOCAL REG. 10-30-1960		26. REGISTRAR'S SIGNATURE <i>[Signature]</i>		

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

MAY - 6 1965

C. L. MARTIN, D.O.

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by _____, Student Embalmer No. _____ or by _____, Student Embalmer No. _____ working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed Nova E. Foster
Nova E. Foster

Licensed Embalmer No. 4742

P. O. Address Kirksville, M

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to do 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.