

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-62-008596

STATE FILE NUMBER

318

1003

2732

Registration District No. _____ Primary Registration District No. _____ Registrar's No. _____

DO NOT WRITE ON THIS STUB

AMENDED

FILED MAR 15 1962

1. PLACE OF DEATH a. COUNTY _____ b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis Length of stay in lb _____ c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION St. John's Hospital Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo. b. COUNTY St. Louis c. CITY OR TOWN Webster Groves Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/> d. STREET ADDRESS (If outside, give location) 135 S. Laclede Station Rd. Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First BERNARD Middle A. Last PRANGER		4. DATE OF DEATH Month March Day 9 Year 1962					
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 3-29-1873	9. AGE (last birthday) 88	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HR Hours _____ Min. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired). Clerk-(Retired) Mercantile Trust Co.		10b. KIND OF BUSINESS OR INDUSTRY Trust Co.		11. BIRTHPLACE (City and state or country) Carrollton, Ill.		12. CITIZEN OF WHAT COUNTRY U.S.A.	
13a. FATHER'S NAME George Pranger			13b. MOTHER'S MAIDEN NAME Margaret Meiners		14. NAME OF HUSBAND OR WIFE Elizabeth M. Pranger		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Dr. Sam H. Pranger 6363 Wydown Blvd.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchus-Pneumonia INTERVAL BETWEEN ONSET AND DEATH 36 hrs. DUE TO (b) Chronic brain syndrome 2-3 mos DUE TO (c) Cerebral Thrombosis Rt. lent. artery 3 mos ago PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Acute Parotitis (Ch.) 72 hrs. 332x						PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
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 _____ 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 12-5-1961 to 3-9-1962 and last saw her/him alive on 3-9-1962 Death occurred at 1:30 A. m on the date stated above, and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE (Degree or title) John J. Hammond M.D.			22b. ADDRESS 634 N. Grand		22c. DATE SIGNED 3/9/62		
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal (Mtr)		23b. DATE Mar. 12, 1962		23c. NAME OF CEMETERY OR CREMATORY Carrollton, Ill.		23d. LOCATION (City, town, or county) (State) _____	
24. FUNERAL DIRECTOR Kriegshauser 4228 S. Kingshighway Blvd.			25. DATE RECD. BY LOCAL REG. MAR 12 1962		26. REGISTRAR'S SIGNATURE Loan Smith, M.D.		

DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

USE BLACK INK OR TYPEWRITER RIBBON

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Rev. 4/59

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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: Ernest W. Pillars
Licensed Embalmer No. 4080

P. O. Address _____

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.