

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-62-017167

DO NOT WRITE  
ON THIS STUB

AMENDED

Registration District No. **318**

Primary Registration District No. **1003**

Registrar's No. **3904**

STATE FILE NUMBER

**FILED APR 25 1962**

VS 300  
Rev. 4/59

1

2 *215*

3

4 *0*

5 *2*

6

7 *0*

8 *2*

9

10

11

12 *90-0*

13

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

1. PLACE OF DEATH a. COUNTY		b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN		Length of stay in 1b 3 yrs		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Mo</b> b. COUNTY		c. CITY OR TOWN <b>St Louis</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>			
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>SilverHasHoteh</b>				Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <b>4443 Taft</b>				Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <b>Urban Prost</b>			4. DATE OF DEATH Month Day Year <b>Apr 13 62</b>			5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>			
8. DATE OF BIRTH <b>7/11/1878</b>		9. AGE (last birthday) <b>83</b>		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HR		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Lumber Mill</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Lumber</b>			
11. BIRTHPLACE (City and state or country) <b>Perry Co Mo</b>				12. CITIZENSHIP OF WHAT COUNTRY <b>USA</b>				13a. FATHER'S NAME <b>Narcis Prost</b>		13b. MOTHER'S MAIDEN NAME <b>Mary Frioux</b>		14. NAME OF HUSBAND OR WIFE <b>---</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>						17. INFORMANT Address <b>78 Roy Prost 4443 Taft</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 Pulmonary Hemorrhage</b> DUE TO (b) <b>Pulmonary Carcinomatosis 1961</b> DUE TO (c) <b>Carcinoma of Prostate 1958</b>										INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>177X</b>										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 <b>July 1953</b> to <b>April 13, 1962</b> and last saw him alive on <b>April 8, 1962</b> Death occurred at <b>12:30 P.M.</b> on the date stated above, and to the best of my knowledge, from the causes stated.													
22a. SIGNATURE (Degree or title) <b>Thomas F. Summers, M.D.</b>						22b. ADDRESS <b>3624 S. Broadway</b>			22c. DATE SIGNED <b>4-13-61</b>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>		23b. DATE <b>4/16/62</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Mt Hope</b>		23d. LOCATION (City, town, or county) <b>Perryville Mo</b>		STATE (State)					
24. FUNERAL DIRECTOR <b>Ortmann F Home 9222 Lackland Overland Mo</b>						25. DATE RECD. BY LOCAL REG. <b>APR 14 1962</b>		26. REGISTRAR'S SIGNATURE <b>Leon Smith, M.D.</b>					

90

**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 Al C. Orntman

Licensed Embalmer No. 3478

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.