LOCAL REGISTRAR'S RECORD—DO NOT TEAR LEAF OUT

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH 25437

1 PLACE OF DEATH

County Caldwell.

Township ~~Grant.~~ or Village or City Polo.

Registration District No. 99 Primary Registration District No. 4061

File No. Registered No.

(NO. , St.; Ward) [If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME Priscilla Frances Pryor.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word): Married

6 DATE OF BIRTH: Jan. (Month) 26th. (Day), 1841 (Year)

7 AGE: 80 yrs. 8 mos. 22 ds. If LESS than 1 day, hrs. or min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work: Housewife.
(b) General nature of industry business, or establishment in which employed (or employer):

9 BIRTHPLACE (City or town, State or foreign country): Williamsburg Kentucky.

PARENTS

10 NAME OF FATHER: William Braughton

11 BIRTHPLACE OF FATHER (City or town, State or foreign country): Kentucky.

12 MAIDEN NAME OF MOTHER: Jennie Cobb.

13 BIRTHPLACE OF MOTHER (City or town, State or foreign country): Kentucky.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs Zoe Hendricks.
(Address) Topeka Kansas.

15 Filed Oct 18, 191.. R. L. Mount Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: Oct (Month) 18 (Day), 1921 (Year)

17 I HEREBY CERTIFY, that I attended deceased from July 5, 1921, to Oct 17, 1921, that I last saw her alive on Oct 17, 1921, and that death occurred, on the date stated above, at 10 P m.

The CAUSE OF DEATH* was as follows: Gangrene of Foot

(Duration) yrs. 2 mos. ds.

CONTRIBUTORY (Secondary)
(Duration) yrs. mos. ds.

(Signed) R. L. Mount M. D.
Oct 18, 1921 (Address) Polo Mo

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)
At place of death yrs. mos. ds. In the State yrs. mos. ds.
Where was disease contracted if not at place of death?
Former or usual residence

19 PLACE OF BURIAL OR REMOVAL: Zimmerman Cemetery
DATE OF BURIAL: Oct 18th 1921.

20 UNDERTAKER: Alspaugh & Cooley
ADDRESS: Polo Mo.

CERTIFICATE OF DEATH

County .....

Township ..... Registration District No. ..... File No. .....
or
Village ..... Primary Registration District No. ..... Registered No. .....
or
City ..... (NO. ....., ... St.: ..... Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME .....

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 SINGLE MARRIED WIDOWED OR DIVORCED (*Write* the word)

6 DATE OF BIRTH .....
..... (Month) ..... (Day) ..... 1..... (Year)

7 AGE .....yrs. .....mos. .....ds.

If LESS than 1 day, ...hrs. or .....min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work .....
(b) General nature of industry business or establishment in which employed (or employer) .....

9 BIRTHPLACE (City or town, State or foreign country)

PARENTS

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (City or town, State or foreign country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (City or town, State or foreign country)

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) .....
(Address) .....

15
Filed ....., 191....., ...
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH
..... (Month) ..... (Day) ..... 191..... (Year)

17 I HEREBY CERTIFY, that I attended deceased from ....., 191....., to ....., 191.....,
that I last saw h.....alive on ....., 191.....,
and that death occurred, on the date stated above, at .....m.

The CAUSE OF DEATH* was as follows:

.....
.....
..... (Duration) .....yrs. .....mos. .....ds.

CONTRIBUTORY (Secondary) .....
..... (Duration) .....yrs. .....mos. .....ds.

(Signed) ..... M. D.
....., 191..... (Address) .....

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)
At place of death .....yrs. .....mos. .....ds. In the State .....yrs. .....mos. .....ds.
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19 PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL ....., 191.....
20 UNDERTAKER	ADDRESS

SCHEDULE: Sub-only. Definite synonym is "Epidemic cerebrospinal meningitis"; *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report *Cerebrospinal fever*).

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

[illegible] to cause and causation, using always the same accepted term for the same disease. Examples: [illegible] vast improvement, and its scope can be extended at a late date.