

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

Do not use this space.

12953

1. PLACE OF DEATH

County.....

Registration District No. **791**

Township.....

Primary Registration District No. **1003**

City St Louis Mo (No. 4868 Mountain Ave St. Ward)

File No.

Registered No. **3227**

2. FULL NAME Julia D Pryor

(a) Residence No. St. 12 Ward.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. da.

How long in U.S., if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Female

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)

Widow

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF

Widow George R. Pryor

6. DATE OF BIRTH (MONTH, DAY AND YEAR)

July 20th 1850

7. AGE

YEARS

MONTHS

DAYS

If LESS than 1 day, hrs. or min.

76

8

11

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work

at Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN)

Georgetown Ky

(STATE OR COUNTRY)

10. NAME OF FATHER

J. S. Deering

11. BIRTHPLACE OF FATHER (CITY OR TOWN)

Georgetown Ky

(STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER

Martha Wall

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)

Hartford Ky

(STATE OR COUNTRY)

14.

INFORMANT Miss Julia D. Pryor

(Address) 4868 Mountain Ave

15.

APR - 3 1927
FILED 19

Man C Starceff
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR)

Apr 1 19 27

17.

I HEREBY CERTIFY, That I attended deceased from Jan 15, 1927, to Apr 1, 1927.

that I last saw him 4 alive on Mar 1, 1927, and that death occurred, on the date stated above, at 10 15 P.M.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

1927
133
Acute Bronchitis non Tubercular (duration) yrs. mos. 10 da.

CONTRIBUTORY (SECONDARY) from a cold (duration) yrs. 3 mos. da.

18. WHEN WAS DISEASE CONTRACTED

4868th Mountain Ave

IF NOT AT PLACE OF DEATH: Place of death

DID AN OPERATION PRECEDE DEATH? No DATE OF 7

WAS THERE AN AUTOPSY? No

WHAT TEST CONFIRMED DIAGNOSIS? nasal symptoms

(Signed) William T. Husk, M. D.

4 2, 1927 (Address) 3500 N Grand

19. PLACE OF BURIAL, CREMATION, OR REMOVAL

DATE OF BURIAL

Nicholasville Ky April 3rd 1927

20. UNDERTAKER

ADDRESS

Walt Hermann Son 4103rd Flourissant

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.

