

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

23199

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
DEC 17 1940

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 39198
Registrar's No. 310

Registration District No. 547 Primary Registration District No. 3029

1. PLACE OF DEATH:
(a) County Marion
(b) City or town Hannibal
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
Levering Hoop
(If not in hospital or institution, write street number or location) 1
(d) Length of stay: In hospital or institution _____ (Specify whether _____)
In this community _____ years, months or days

3. (a) PRINT FULL NAME Charles Pryor
3. (b) If veteran, name war _____ 3. (c) Social Security No. _____
4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Divorced
6. (b) Name of husband or wife Ora Long 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased October 22, 1878
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>62</u>		<u>8</u>	_____hr. _____min.

9. Birthplace Frankford Missouri
(City, town, or county) (State or foreign country)
10. Usual occupation Farmer

11. Industry or business _____
12. Name Dr. C.L. Pryor
13. Birthplace Ohio
(City, town, or county) (State or foreign country)
14. Maiden name Mary Kiece
15. Birthplace Pike County Missouri
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Sue Lowry - Ex Smith
(b) Address 3524 Market

17. (a) Burial (b) Date thereof 10/31/40
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Frankford

18. (a) Signature of funeral director Lorawford Smith
(b) Address 902 Broadway, Hannibal

19. (a) Nov 1 - '40 (b) H. C. Fisher
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County Rolls
(c) City or town New London
(If outside city or town limits, write "RURAL")
(d) Street No. 0
(If rural, give location)
(e) If foreign born, how long in U. S. A.? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month October day 30
year 1940 hour 2 minute 00 AM.
21. I hereby certify that I attended the deceased from Oct 27
1940, to Oct 30, 1940
that I last saw him alive on Oct 29, 1940
and that death occurred on the date and hour stated above.

Immediate cause of death Intestinal obstruction
Due to Band of adhesions
Due to _____
Other conditions _____
(Include pregnancy within 3 months of death)

Major findings: Intestinal obstruction + inflammation
Of operations _____
Of autopsy _____

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify) _____
(b) Date of occurrence _____
(c) Where did injury occur? _____ (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

While at work? _____ (Specify type of place) (e) Means of injury _____
23. Signature W S Waters (M. D. or other) _____
Address New London Mo Date signed 10/31/40

Duration _____
PHYSICIAN _____
Underline the cause to which death should be charged statistically.

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.....

....., Registered Apprentice No.....
working under my personal supervision.

Signed.....

Joseph J. Marsh

Licensed Embalmer No. 3932.....

P. O. Address Hannibal Missouri.....

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.