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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **14797**

FILED APR 27 1945

Registration District No. **333**

Primary Registration District No. **50-6196**

Registrar's No. **10**

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

1. PLACE OF DEATH:

(a) County Texas

(b) City or town Licking Shoemaker
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution _____
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution _____
(Specify whether _____)

In this community _____
years, months or days

3. (a) PRINT FULL NAME William Pryor

3. (b) If veteran, name war _____

(c) Social Security No. _____

4. Sex M 5. Color or race W

6. (a) Single, widowed, married, divorced, widowed

(b) Name of husband or wife Abelene Pryor 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased Jan 24, 1853
(Month) (Day) (Year)

8. AGE: Years 92 Months _____ Days 25 If less than one day _____ hr. _____ min.

9. Birthplace Shoemaker, Mo
(City, town, or county) (State or foreign country)

10. Usual occupation Parenting

11. Industry or business _____

12. Name LeRoy Pryor

13. Birthplace Tenn
(City, town, or county) (State or foreign country)

14. Maiden name Miss Mayberry

15. Birthplace Tenn
(City, town, or county) (State or foreign country)

16. (a) Informant A. E. Hesse

(b) Address Licking Mo

17. (a) Buried (b) Date thereof 2-21-45
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Licking Mo

18. (a) Signature of funeral director Smith

(b) Address Licking Mo

19. (a) 4-12-45 (b) Mayberry
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State MO (b) County Texas

(c) City or town Licking
(If outside city or town limits, write "RURAL")

(d) Street No. _____ (If rural, give location)

(e) Citizen of foreign country? no (Yes or No)

If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 2 day 19
year 1945 hour 8 minute 150 M.

21. I hereby certify that I attended the deceased from _____
1943 to Feb 19, 1945
that I last saw him alive on State 18, 1943
and that death occurred on the date and hour stated above.

Immediate cause of death Chronic Hepatitis

Due to old age

Due to _____

Other conditions (Include pregnancy within 3 months of death) _____

Major findings: Of operations 13/18

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)

(a) Means of injury _____

23. Signature J. H. Lee (M.D. or other)

Address Licking Mo Date signed 2/20/45

Duration _____

PHYSICIAN _____

Underline the cause to which death should be charged statistically.

1237

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED

District Health Officer No. 5,

District File Number 485-220

Date Filed 7, 24, 45.

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.....

Not Embalmed, Registered Apprentice No.....
working under my personal supervision.

Signed Robert E. Ferguson
Licensed Embalmer No. 3945
P. O. Address LeKing MO

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