

OVER JUN 29 1945

Registration District No. 179

Primary Registration District No. 1002

Registrar's No.

1. PLACE OF DEATH:

(a) County **Jackson**  
(b) City or town **Kansas City**  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
**General Hospital No. 2**  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution **5-31-45 - 6-8-45**  
(Specify whether years, months or days)  
In this community **43 yr.**

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **Jackson**  
(c) City or town **Kansas City**  
(If outside city or town limits, write "RURAL")  
(d) Street No. **2002 1/2 Olive**  
(If rural, give location)  
(e) Citizen of foreign country? **no** (Yes or No)  
If yes, name country

3. (a) PRINT FULL NAME **HOWARD PRYOR**

3. (b) If veteran, name war **None** 3. (c) Social Security No. **None**

4. Sex **male 9** 5. Color or race **Negro** 6. (a) Single, widowed, married, divorced, **married**  
6. (b) Name of husband or wife **Famie Pryor** 6. (c) Age of husband or wife if alive **70** years  
7. Birth date of deceased **May 2 1872**  
(Month) (Day) (Year)

8. AGE: Years **73** Months **1** Days **6** If less than one day  
hr. min.

9. Birthplace **Centralia Missouri**  
(City, town, or county) (State or foreign country)

10. Usual occupation **none**

11. Industry or business

12. Name **Jarrett Pryor**  
13. Birthplace **Mo. 0**  
(City, town, or county) (State or foreign country)  
14. Maiden name **Mary**  
15. Birthplace **unk 9**  
(City, town, or county) (State or foreign country)

16. (a) Informant **Record Clk.**  
(b) Address **Gen. Hos p. #2.**

17. (a) **burial** (b) Date thereof **6/11/45**  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Centralia, Mo.**

18. (a) Signature of funeral director **Walter Bise**

(b) Address **1729 1/2**

19. (a) **6-11-45** (b) **Geraldine Helms**  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **June** day **8**  
year **1945** hour **8:10** minute **a.** M.

21. I hereby certify that I attended the deceased from **May 31** 19 **45** to **June 8** 19 **45**;  
that I last saw h. **im** alive on **June 8** 19 **45**;  
and that death occurred on the date and hour stated above.

Immediate cause of death **Hypertensive type heart disease with decompensation**

Duration

Due to

Due to

Other conditions (Include pregnancy within 3 months of death) **93 d**

Major findings: Of operations

Of autopsy

PHYSICIAN

Underline the cause to which death should be charged statistically.

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) (b) Means of injury **0**

23. Signature **Walter Bise** (M. D. or other)  
Address **Gen. Hos #2 - 600 E. 22** Date signed **6-11-45**

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

19  
339

**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 Jerome Malone

Licensed Embalmer No. 3994

P.O. Address 2503 Highland

**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.**