V. S. No. 2
50M—9-4-41
Rev. 5-17-39
I X29484

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

FILED AUG 2 1946

State File No. 22788

Registration District No. 42 Primary Registration District No. 1000 Registrar's No. 863

1. PLACE OF DEATH:
(a) County: Buchanan
(b) City or town: St Joseph (If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: St Joseph Hosp #2 (If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 9 Mo 25 Da (Specify whether years, months or days) In this community 9 Mo - 25 Days

2. USUAL RESIDENCE OF DECEASED:
(a) State: Mo (b) County: Clay
(c) City or town: Kansas City, E. Kansas (If outside city or town limits, write "RURAL")
(d) Street No.: Jackson Hotel Kansas City (If rural, give location)
(e) Citizen of foreign country? ..... (Yes or No)
If yes, name country .....

3. (a) PRINT FULL NAME: Sarah Frances Pryor
3. (b) If veteran, name war: None
3. (c) Social Security No.: None
4. Sex: F
5. Color or race: W
6. (a) Single, widowed, married, divorced: W
6. (b) Name of husband or wife: Husband
6. (c) Age of husband or wife if alive: 1859 years
7. Birth date of deceased: Aug (Month) 22 (Day) 1859 (Year)
8. AGE: Years 86 Months 11 Days 9 If less than one day ..... hr. ..... min.
9. Birthplace: Iowa (City, town, or county) (State or foreign country)
10. Usual occupation: Housewife
11. Industry or business: ...
12. FATHER Name: Wiley Kincaid
13. FATHER Birthplace: — — — Iowa (City, town, or county) (State or foreign country)
14. MOTHER Maiden name: Lelia Wilson
15. MOTHER Birthplace: — — — Iowa (City, town, or county) (State or foreign country)
16. (a) Informant: Mrs Lida Yarrell
(b) Address: 10 Highland Kansas City Mo
17. (a) Burial, cremation, or removal: Burial (b) Date thereof: 7/31/46 (Month) (Day) (Year)
(c) Place: burial or cremation: Richmond Missouri
18. (a) Signature of funeral director: Guest Lib Funeral Home
(b) Address: Richmond Missouri
19. (a) Date received local registrar: July 31, 1946 (b) C. J. Nestlehuch (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 31 year 1946 hour 7 minute 0 A. M.
21. I hereby certify that I attended the deceased from July 19, 1946, to July 31, 1946, that I last saw her alive on July 30, 1946, and that death occurred on the date and hour stated above.

Immediate cause of death: Bronchial pneumonia — Duration 3 days
Due to: .....
Due to: .....
Other conditions (Include pregnancy within 3 months of death): .....
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? (Specify type of place)
While at work? ..... (e) Means of injury: .....
23. Signature: L. L. Finch M.D. (M. D. or other)
Address: State Hospital #2 Date signed 7/31/46

34 (Licensed Embalmer's Statement on Reverse Side)

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.....

Licensed Embalmer No. 4066

P. O. Address Richmond, 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.