

S. No. 2
M-5-43
5-17-39
X36671

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED NOV 25 1946

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **36499**

Registration District No. **87**

Primary Registration District No. **3017**

Registrar's No. **110**

1. PLACE OF DEATH:

(a) County Cooper

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

(c) Name of hospital or institution: Van Ravenswaay Clinic
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 2 Days
(Specify whether years, months or days)

In this community Life Time

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Morgan **71**

(c) City or town Versailles Rural
(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 _____

3. (a) PRINT FULL NAME James Alfred Pryor

3. (b) If veteran, name war None

3. (c) Social Security No. None

4. Sex M **5. Color or race** W

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

6. (b) Name of husband or wife None **6. (c) Age of husband or wife if alive** _____ years

7. Birth date of deceased March 6, 1937
(Month) (Day) (Year)

8. AGE: Years 9 Months 7 Days 26 If less than one day hr. min.

9. Birthplace Miller County Missouri
(City, town, or county) (State or foreign country)

10. Usual occupation School Boy

11. Industry or business _____

MOTHER FATHER

12. Name Eddy Pryor

13. Birthplace Morgan County Missouri
(City, town, or county) (State or foreign country)

14. Maiden name Lillie Orvin

15. Birthplace Morgan County Missouri
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs Lillie Pryor

(b) Address Versailles, Missouri

17. (c) Removal Nov. 2-46
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Versailles, Cemetery

18. (a) Signature of funeral director W. F. Kimmel

(b) Address Versailles, Missouri

19. (a) 11-8-46 **(b) W. Hooper**
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov day 2 year 1946 hour 5 am minute _____ M.

21. I hereby certify that I attended the deceased from Oct 30 1946 to Nov 2 1946
that I last saw him alive on Nov 1 1946
and that death occurred on the date and hour stated above.

Immediate cause of death Ruptured appendix **Duration** 4

Due to Causing peritonitis and general septicemia

Due to None under observation

Other conditions 110 2es if an a gamal infection

Major findings: See above

Of operations _____

Of autopsy None 121

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? 0

While at work _____ (Specify type of place) **(e) Means of injury** _____

23. Signature W. Hooper (M. D. or other) **Address** Boonville Mo **Date signed** Nov 2 1946

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

RECEIVED

District Health Officer No. 8,

District File Number.....

Date Filed 1-23-46

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 *E. F. Keckell*

Licensed Embalmer No. 1596

P. O. Address *Wesley, 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.