

No. 2
5-17-39
X35571

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED JUN 14 1947

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

16694

State File No. _____
Registrar's No. 37

Registration District No. 44

Primary Registration District No. 5153-

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

2. USUAL RESIDENCE OF DECEASED:
(a) State Wisconsin (b) County 99th
(c) City or town Mauston 147
(If outside city or town limits, write "RURAL")
(d) Street No. _____ (If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME Leo William Prosser
3. (b) If veteran, name war _____ 3. (c) Social Security No. 468-18-4551

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month April day 20
year 1947 hour _____ minute _____ M.

4. Sex male 5. Color or race W
6. (a) Single, widowed, married, divorced S
6. (b) Name of husband or wife _____
6. (c) Age of husband or wife if alive _____ years

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____;
that I last saw him _____ alive on _____, 19____;
and that death occurred on the date and hour stated above.

7. Birth date of deceased January 24, 1900
(Month) (Day) (Year)

Immediate cause of death Accidental
Found dead on Rock Island
railroad track near Shoal
Station, Both legs cut off

8. AGE: Years Months Days If less than one day
47 2 26 hr. _____ min.

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

9. Birthplace Necedah Wisconsin
(City, town, or county) (State or foreign country)

Major findings: Of operations _____
Of autopsy _____
169-8
30

10. Usual occupation Railroad Laborer
11. Industry or business _____
12. Name Daniel Prosser
13. Birthplace Grinnell Wisconsin
(City, town, or county) (State or foreign country)

14. Maiden name Mary Kennedy
15. Birthplace Quebec Canada
(City, town, or county) (State or foreign country)

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify) Accident
(b) Date of occurrence April 20 1947

16. (a) Informant Mrs Mary Galvin
(b) Address Lyndon Station Wisconsin
17. (a) burial (b) Date thereof 4-26-1947
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Kingston Cemetery

(c) Where did injury occur? Rural Caldwell-Mo.
(City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place?
Public Place. Run over
While at work _____ (Specify type of place)
(e) Means of injury by train

18. (a) Signature of funeral director Cramer Clark
(b) Address Kingston, Missouri
19. (a) 6-4-47 (b) Mrs. Nell B. Jones
(Date received local registrar) (Registrar's signature)

23. Signature Cramer Clark Coroner
Address Kingston, Mo. Date signed 4/20/47

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

MOTHER FATHER

**DISTRICT HEALTH OFFICE
Cameron, Mo.**

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..... *Cramer Clark*

Licensed Embalmer No..... 3257

P. O. Address Kingston, 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.

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUSTHE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATHState File No. *June*Registration District No. *47*Primary Registration District No. *5155*Registrar's No. *37*

1. PLACE OF DEATH:

- (a) County *Caldwell*
 (b) City or town *Reed*
 (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*Leo W. Prosser*

3. (b) If veteran,
-
- name war _____

3. (c) Social Security
-
- No. _____

4. Sex
- m*
-
- Color or race
- w*

6. (a) Single, widowed, married,
-
- divorced
- single*

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

7. Birth date of deceased
- Jan 24*
-
- (Month) (Day) (Year)

8. AGE: Years
- 47*
- Months _____ Days _____
-
- If less than one day
-
- hr. _____ min. _____

9. Birthplace
- Luis*
-
- (City, town, or county) (State or foreign country)

10. Usual occupation

11. Industry or business

12. Name _____
 13. Birthplace _____
 (City, town, or county) (State or foreign country)
 14. Maiden name _____
 15. Birthplace _____
 (City, town, or county) (State or foreign country)

16. (a) Informant _____
 (b) Address _____
 17. (a) _____ (b) Date thereof _____
 (Burial, cremation, or removal) (Month) (Day) (Year)
 (c) Place: burial or cremation _____

13. (a) Signature of funeral director _____
 (b) Address _____

19. (a) _____ (b) _____
 (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

- (a) State _____ (b) County _____
 (c) City or town _____
 (If outside city or town limits, write "RURAL")
 (d) Street No. _____
 (If rural, give location)
 (e) Citizen of foreign country? _____ (Yes or No)
 If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month _____
-
- Year
- 1942*
- hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____ to _____, 19____;
 that I last saw him _____ alive on _____, 19____;
 and that death occurred on the date and hour stated above.
 Immediate cause of death _____

Duration

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 sta-
tistically.

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 _____ (M. D. or other)

Address _____ Date signed _____

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

SUPPLEMENTARY

AUG 25 1947

16694