

FILED FEB 12 1951

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 43622

BIRTH NO. _____ REG. DIST. NO. 17E PRIMARY REG. DIST. NO. 5-63-4 Registrar's No. 150

1. PLACE OF DEATH a. COUNTY Lawrence		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE MISSOURI b. COUNTY LAWRENCE	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Rural Ozark		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Rural Ozark	
c. LENGTH OF STAY (to this place) 6 yrs		d. STREET ADDRESS (If rural, give location) Ash Grove R#3	
d. FULL NAME OF HOSPITAL OR INSTITUTION Ash Grove R#3			

3. NAME OF DECEASED (Type or Print) JOHN HENRY PRICHARD	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year) 12-30-50
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5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Never Married	8. DATE OF BIRTH 6-4-1879	9. AGE (In years last birthday) 79	IF UNDER 1 YEAR Days 6	IF UNDER 24 HRS. Hours Min. 26
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer	10b. KIND OF BUSINESS OR INDUSTRY Farm	11. BIRTHPLACE (State or foreign country) Ark. 1	12. CITIZEN OF WHAT COUNTRY USA
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13a. FATHER'S NAME BROWN PRICHARD	13b. MOTHER'S MAIDEN NAME Rhoda Robertson	14. NAME OF HUSBAND OR WIFE
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, name unknown) (If yes, give war or dates of service) No	16. SOCIAL SECURITY NO.	17. INFORMANT'S SIGNATURE AND NAME Mrs. Ed. Wright	ADDRESS Ash Grove R#3
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18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asphyxia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH 48 hrs. 15X
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Toxemia		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Primary Gastric Carcinoma DUE TO (c)		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?
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22. I hereby certify that I attended the deceased from Nov 1949, to 12-30, 1950, that I last saw the deceased alive on Dec 29, 1950, and that death occurred at 12:05 p.m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) Homer F. Matz No. 2	23b. ADDRESS Ash Grove, Mo.	23c. DATE SIGNED 12-30-50
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24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE 12-31-50	24c. NAME OF CEMETERY OR CREMATORY Halltown Cemetery	24d. LOCATION (City, town, or county) (State) Halltown Mo.
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DATE REC'D BY LOCAL REG. 1-9-51	REGISTRAR'S SIGNATURE W. S. Beatty	158	25. FUNERAL DIRECTOR'S SIGNATURE AND ADDRESS Sun Funeral Service Ash Grove Mo.
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

DIVISION OF HEALTH OF MO.

District No. 5 - Springfield

RECEIVED FEB 19 1971

Dist. File 257-341

Date Filed 2-9-71

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 _____

Student Embalmer No. _____

working under my personal supervision.

Student
Student Embalmer

Signed _____

Licensed Embalmer No. 4005

P. O. Address: Cash Grove

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.