

FILED JUL 19 1955

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATHState File No. **22543**BIRTH NO. \_\_\_\_\_ REG. DIST. NO. **146** PRIMARY REG. DIST. NO. **5568** Registrar's No. **247**

1. PLACE OF DEATH a. COUNTY <b>Jackson</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <b>Missouri</b> b. COUNTY <b>Jackson</b>	
b. CITY (If outside corporate limits, write RURAL and give town) <b>Rural Blue</b>	c. LENGTH OF STAY (in this place) <b>24yrs</b>	c. CITY OR TOWN <b>Rural</b>	d. Is residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
d. FULL NAME OF HOSPITAL-OR INSTITUTION <b>T.C. Lee &amp; Frandsen Roads</b>		f. STREET ADDRESS (If rural, give location) <b>T.C. Lee &amp; Frandsen Rds.</b>	

3. NAME OF DECEASED (Type or Print)	a. (First) <b>MR. CHRISTOPHER</b>	b. (Middle) _____	c. (Last) <b>PRANTLE</b>	4. DATE OF DEATH (Month) (Day) (Year) <b>June 30, 1955</b>
-------------------------------------	-----------------------------------	-------------------	--------------------------	--

5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>Widowed</b>	8. DATE OF BIRTH <b>Jan. 10, 1885</b>	9. AGE (In years last birthday) <b>70</b>	if UNDER 1 YEAR Months _____ Days _____	if UNDER 24 HRS. Hours _____ Min. _____
--------------------	-------------------------------	---	---------------------------------------	---	---	---

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Railroad Switchman. (C&amp;A)</b>	10b. KIND OF BUSINESS OR INDUSTRY _____	11. BIRTHPLACE (City and State or Foreign Country) <b>Kansas City, Mo.</b>	12. CITIZEN OF WHAT COUNTRY? <b>USA</b>
--	---	--	---

13a. FATHER'S NAME <b>George Prantle</b>	13b. MOTHER'S MAIDEN NAME <b>Katherine ?</b>	14. NAME OF HUSBAND OR WIFE <b>--</b>
--	--	---------------------------------------

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>	16. SOCIAL SECURITY NO. <b>709-10-9128</b>	17. INFORMANT'S SIGNATURE OR NAME <b>Mrs Kate Milton</b>	ADDRESS <b>609E. College Ind.</b>
---	--	--	-----------------------------------

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, ashenia, etc. It means the disease, injury, or complication which caused death.	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Coronary Occlusion.</b>		INTERVAL BETWEEN ONSET AND DEATH <b>6-22-55</b>
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <b>Arteriosclerotic Heart disease</b>		
	DUE TO (c) <b>H200</b>		
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 type="checkbox"/>
------------------------------	--	---

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) _____
--	--	---

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? _____
---	--	----------------------------------

22. I hereby certify that I attended the deceased from **1940** to **6-30**, 19**55**, that I last saw the deceased alive on **6-28**, 19**55**, and that death occurred at **7a** m., from the causes and on the date stated above.

23. SIGNATURE <b>Dred Ammar</b> (Degree or title) _____	23b. ADDRESS <b>Indep. Mo</b>	23c. DATE SIGNED <b>6/30/55</b>
---	-------------------------------	---------------------------------

24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	24b. DATE <b>July 2, 1955</b>	24c. NAME OF CEMETERY OR CREMATORY <b>St. Washington</b>	24d. LOCATION (City, town, or county) (State) <b>K.C. Mo</b>
---	-------------------------------	--	--

DATE REC'D BY LOCAL REG. <b>7-2-55</b>	REGISTRAR'S SIGNATURE <b>[Signature]</b>	25. FUNERAL DIRECTOR'S SIGNATURE <b>[Signature]</b>	ADDRESS <b>Indep. Mo.</b>
--	--	---	---------------------------

(Licensed Embalmer's Statement on Reverse Side)

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

JAN 8 0 1957

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.....  
Signature of Student Embalmer

Signed *[Handwritten Signature]*  
.....

Licensed Embalmer No. *315*

P. O. Address *Indep.*

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.  
If this body is not embalmed, fact should be so stated above.