

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

16266

STATE FILE NUMBER

FILED MAY 20 1957

Registration District No. 42 Primary Registration District No. 1000 Registrar's No. 518

Health, Welfare Public Service

300 1-56

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related. Coroner cannot certify to a death due to natural causes.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

1. PLACE OF DEATH a. COUNTY <u>Buchanan</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Livingston</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>St. Joseph</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN <u>Chillicothe</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>State Hospital #2</u> Length of stay in lb <u>1 yr., 1 mo.</u>		d. STREET ADDRESS (If outside, give location) <u>820 3rd Street</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Leon</u> Middle <u>Pringle</u> Last <u>Pringle</u>			4. DATE OF DEATH Month <u>5</u> Day <u>9</u> Year <u>1957</u>
5. SEX <u>Male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>August 25, 1872</u>
9. AGE (In years to birthday) <u>84</u>		IF UNDER 1 YEAR Months <u>1</u> Days <u>5</u> Hours <u>5</u> Min. <u>0</u>	IF UNDER 24 HRS. Hours <u>5</u> Min. <u>0</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>store clerk, carpenter,</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>blacksmith shop/</u>	11. BIRTHPLACE (City and state or country) <u>Jersey, Ohio</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>William Pringle</u>	
14. MOTHER'S MAIDEN NAME <u>Harriett Limbuner</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>?</u> (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT Address <u>State Hospital #2, St. Joseph, Mo.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerosis general</u> DUE TO (b) <u>Fracture left femur</u> DUE TO (c) <u>9027</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Fracture left hip as a result of fall 45</u>			INTERVAL BETWEEN ONSET AND DEATH <u>20 years 3 months</u>
20a. ACCIDENT <input checked="" type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Patient Fell from bed</u>		
20c. TIME OF INJURY Hour <u>131</u> Month, Day, Year <u>1st week in February 1957</u>	20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		
20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) <u>Ward 8 Hospital</u>		20f. CITY, TOWN, OR LOCATION COUNTY STATE <u>State Hospital #2 St. Joseph Mo</u>	
21. I attended the deceased from <u>Feb. 27-1957</u> to <u>May 9-1957</u> and last saw <u>him</u> alive on <u>May 9-1957</u> . Death occurred at <u>9:15 AM</u> on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <u>Mohammed Eshu M.D.</u>		22b. ADDRESS <u>State Hospital #2</u>	22c. DATE SIGNED <u>5-9-57</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>removal</u>	23b. DATE <u>5/9/1957</u>	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City, town, or county) (State) <u>Chillicothe, Mo.</u>
24. FUNERAL DIRECTOR ADDRESS <u>Heaton-Bowman, St. Joseph, Mo.</u>		25. DATE RECD. BY LOCAL REG. <u>May 10, 1957</u>	26. REGISTRAR'S SIGNATURE <u>Ethel M. Allison</u>

(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 Student Embalmer No. working under my personal supervision.

Student
Signature of Student Embalmer

Signed *William Spalding*
Licensed Embalmer No. *4530*

P. O. Address *319 S. 104 St*

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.