

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-046993

STATE FILE NUMBER

360

3076

Registrar's No. 226

FILED DEC 16 1958

Registration District No.

Primary Registration District No.

300
1-57

1. PLACE OF DEATH a. COUNTY <u>Vernon</u>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Vernon</u>		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Nevada</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>Nevada</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>Nevada Hospital</u>		Length of stay in lb <u>Lifetime</u>	d. STREET ADDRESS (If outside, give location) <u>R#1</u>		Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>ORBA</u> Middle <u>HOWARD</u> Last <u>PRYOR</u>			4. DATE OF DEATH Month <u>November</u> Day <u>30</u> Year <u>1958</u>		
5. SEX <u>M</u>	6. COLOR OR RACE <u>Wh</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>April 30, 1903</u>		9. AGE (In years last birthday) <u>55</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farming, Carpenter</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Self employed</u>		11. BIRTHPLACE (City and state or country) <u>Stotesbury Missouri</u>	
10c. FATHER'S NAME <u>James L. Pryor</u>		13b. MOTHER'S MAIDEN NAME <u>Daisy Dean Hogan</u>		14. NAME OF HUSBAND OR WIFE <u>Iris Pryor</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO.		17. INFORMANT Address <u>Iris Pryor, R#1, Nevada, Missouri</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>Paralytic ileus</u>					INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Fracture of 1st. & 3rd. lumbar vertebrae</u>					<u>5 days</u>
DUE TO (c) <u>Fall from a scaffold.</u>					<u>5 days</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>6</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>Working on a roof and the scaffolding fell, knocking him down,</u>			
20c. TIME OF INJURY Hour Month, Day, Year a.m. <u>11/25/58</u> p.m.		20d. INJURY OCCURRED WHILE AT <input checked="" type="checkbox"/> NOT WHILE <input type="checkbox"/> WORK AT WORK <u>Ferry Funeral Home</u>			
20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>Ferry Funeral Home</u>		20f. CITY, TOWN, OR LOCATION <u>Nevada</u>		COUNTY STATE <u>Vernon Missouri</u>	
21. I attended the deceased from <u>Nov. 25, 1958</u> to <u>Nov. 30, 1958</u> and last saw him ^{her} alive on <u>Nov. 30, 1958</u> Death occurred at <u>Nevada, Mo.</u> <u>6:55 P.</u> m on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE <u>L. P. McCann, M. D.</u>			22b. ADDRESS <u>Moore Building, Nevada, Mo.</u>		22c. DATE SIGNED <u>12/2/1958.</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>1958</u> <u>December 3</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Olive Branch Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Vernon County Missouri</u>
24. FUNERAL DIRECTOR <u>Ferry Funeral Home Nevada, Missouri</u>		ADDRESS	25. DATE RECD. BY LOCAL REG. <u>12-12-1958</u>		26. REGISTRAR'S SIGNATURE <u>Anna E. Ferry</u>

(Licensed Embalmer's Statement on Reverse Side)

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.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

510

FEB 18 1959

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 *L. Stephen Ferry*

. Licensed Embalmer No. *4960*

P. O. Address *Harvard, Ill.*

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.