

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

59-015572

STATE FILE NUMBER

2 4361

FILED MAY 14 1959 Registration District No. \_\_\_\_\_ Primary Registration District No. \_\_\_\_\_ Registrar No. \_\_\_\_\_

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1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>Dent</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>ST. LOUIS, MISSOURI</b>		c. CITY OR TOWN <b>Salem</b>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>BARNES HOSPITAL</b>		d. STREET ADDRESS (If outside, give location)	

3. NAME OF DECEASED (Type or print) First Middle Last <b>JAMES EDWARD PRYOR</b>			4. DATE OF DEATH Month Day Year <b>MAY 3, 1959</b>		
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <del>WIDOWED</del> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>April 28, 1886</b>	9. AGE (In years last birthday) <b>73</b>	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Independent Packing Co.</b>		11. BIRTHPLACE (City and state or country) <b>Salem, Missouri</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13a. FATHER'S NAME <b>John Pryor</b>		13b. MOTHER'S MAIDEN NAME <b>Martha Brotherton</b>	
14. NAME OF HUSBAND OR WIFE <b>Bertha Pryor</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>unknown</b>			
16. SOCIAL SECURITY NO. <b>unknown</b>		17. INFORMANT Address <b>Mrs. Edward Engel 3241 Childress Ave.</b>			

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>ADENOCARCINOMA OF PANCREAS WITH METASTASES TO PERITONEUM</b>			INTERVAL BETWEEN ONSET AND DEATH <b>FEW MONTHS</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) _____ DUE TO (c) _____ <b>157X</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)			19. WAS AUTOPSY PERFORMED? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO

20a. ACCIDENT <input 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.) <b>ITEM 7, 14 CORRECTED</b>	
20c. TIME OF INJURY Hour a.m. p.m.	BY AFFIDAVIT OF <b>Funeral Director</b> <b>6-8-59 SCL</b>	

20d. INJURY OCCURRED WHILE AT <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.)	20f. CITY, TOWN, OR LOCATION <b>St. Louis Co., Mo.</b>	COUNTY <b>St. Louis Co., Mo.</b>	STATE
21. I attended the deceased from <b>APRIL 15, 1959</b> to <b>MAY 3, 1959</b> and last saw her/him alive on <b>MAY 3, 1959</b> Death occurred at <b>7:00 P.M.</b> m on the date stated above; and to the best of my knowledge, from the causes stated.		22a. SIGNATURE (Degree or title) <b>C. Vermillion, M.D.</b>		
22b. ADDRESS <b>BARNES HOSPITAL</b>		22c. DATE SIGNED <b>5/4/59</b>		

23a. BURIAL, CREMATION, REMOVAL (Specify) <b>removal</b>	23b. DATE <b>5-6-59</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Memorial Park Cemetery</b>	23d. LOCATION (City, town, or country) (State) <b>St. Louis Co., Mo.</b>
24. FUNERAL DIRECTOR ADDRESS <b>Aker Mortuary 4104 Manchester</b>		25. DATE RECD. BY LOCAL REG. <b>MAY 4 '59</b>	26. REGISTRAR'S SIGNATURE <b>Earl Smith, M.D.</b>

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

Occur, coroner, etc.; insert any standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related.

STATEMENT BY LICENSED EMBALMER

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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 *Clarence H. [Signature]*

Licensed Embalmer No. 4375  
P. O. Address At Home 237

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.