

JRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

=60-002453

FILED VS JAN 25 1960

187

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STATE FILE NUMBER

Registration District No. _____ Primary Registration District No. _____ Registrar's No. _____

ENDED

1. PLACE OF DEATH a. COUNTY <u>Livingston</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>Medicine TWP</u>		Length of stay in 1b <u>18 years</u>	c. CITY OR TOWN <u>Chula</u> Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>4 1/2 S.E. Chula</u>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>4 1/2 Mi. S.E. Chula</u> Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>

3. NAME OF DECEASED (Type or print) First Middle Last <u>Garnett Clelland Pryor</u>			4. DATE OF DEATH Month Day Year <u>January 14 1960</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>Oct-8-1910</u>	9. AGE (last birthday) <u>49</u>	IF UNDER 1 YEAR IF UNDER 24 HR Months Days Hours Min. <u>3 6</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farm</u>	11. BIRTHPLACE (City and state or country) <u>Daviess Co Mo</u>	12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13a. FATHER'S NAME <u>Charley C Pryor</u>		13b. MOTHER'S MAIDEN NAME <u>Frankie Shaffer</u>		14. NAME OF HUSBAND OR WIFE <u>Ermelue 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. <u>562-26-0549</u>	17. INFORMANT <u>Ermelue Pryor Chula, Mo.</u> Address		

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a) <u>Coronary Occlusion Posterior</u>		<u>Instant</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <u>Coronary Sclerosis Severe</u>	<u>1 year</u>
	DUE TO (c)	

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
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19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	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.)
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20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year	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.)	20f. CITY, TOWN, OR LOCATION COUNTY STATE
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21. I attended the deceased from <u>Dec. 1-59</u> to <u>Jan 14-60</u> and last saw him alive on <u>Jan 14-60</u> Death occurred at <u>5:30 p.m.</u> on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) <u>Joseph A. Conrad M.D.</u>	22b. ADDRESS <u>Chillicothe, Mo</u>	22c. DATE SIGNED <u>Jan 16-60</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>1/17/1960</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Rickett Cemetery</u>	23d. LOCATION (City, town, or county) (State) <u>Chula Missouri</u>
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24. FUNERAL DIRECTOR <u>F.J. Robertson Funeral Home</u>	ADDRESS <u>Chula Mo</u>	25. DATE RECD. BY LOCAL REG. <u>1-19-60</u>	26. REGISTRAR'S SIGNATURE <u>Francis B. Neel</u>
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(Licensed Embalmer's Statement on Reverse Side)

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

JAN 27 1968

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by _____ or by _____, Student Embalmer No. _____ working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed J. Robertson

Licensed Embalmer No. 4388

P. O. Address Laredo

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.