

Registration District No. 677

Primary Registration District No. 4403

Registrar's No. 113

FILED
OCT 23 1940

1. PLACE OF DEATH:

(a) County Phelps
(b) City or town Rolla
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 9
(Specify whether years, months or days)

3. (a) PRINT FULL NAME August Price

8. (b) If veteran, name war _____ 8. (c) Social Security No. _____

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased Nov 11 - 1885
(Month) (Day) (Year)

8. AGE: Years 54 Months 10 Days 9 If less than one day hr. _____ min.

9. Birthplace Linn Mo. (City, town, or county) (State or foreign country)

10. Usual occupation Farmer

11. Industry or business Farming

12. Name Wiley Price

13. Birthplace Tenn (City, town, or county) (State or foreign country)

14. Maiden name Susan Roberts

15. Birthplace Virginia (City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Elsie Price

(b) Address Rolla Mo.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/22/40 (Month) (Day) (Year)

(c) Place: burial or cremation Shirley Cemetery

18. (a) Signature of funeral director Near Linn, Mo.

(b) Address Mrs. Harry W. Law - Rolla Mo.

19. (a) Sept. 20, 1940 (Date received local registrar) (b) Joe F. Ayers (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Phelps
(c) City or town Rolla
(If outside city or town limits, write "RURAL")
(d) Street No. 0
(If rural, give location)
(e) If foreign born, how long in U. S. A.? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept day 20
year 1940 hour 1:00 minute P. M.

21. I hereby certify that I attended the deceased from Sept 1, 1940 to Sept 26, 1940;
that I last saw him alive on Sept 20, 1940;
and that death occurred on the date and hour stated above.

Immediate cause of death Pulmonary Tuberculosis.

Due to _____

Due to 23

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations _____

Of autopsy _____

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) _____
(b) Date of occurrence _____
(c) Where did injury occur? _____ (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? 6-10
While at work? _____ (Specify type of place) (e) Means of injury _____

23. Signature E. E. Fain (M. D. or other) _____
Address Box 534 Rolla Mo. Date signed 9-20-40

Duration 5 yrs.
PHYSICIAN _____
Underline the cause to which death should be charged statistically.

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

RECEIVED

District Health Officer No. 5,

District File Number 10401037

Date Filed _____

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 _____

Registered Apprentice No. _____

~~working under my personal supervision.~~

Signed _____

Licensed Embalmer No. 3953

P. O. Address Raila

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 this body is not embalmed, above space should be left blank.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

7
State File No. 32829

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

Registration District No. 677

Primary Registration District No. 4403

Registrar's No.

1. PLACE OF DEATH:

(a) County Phelps
(b) City or town Rolla
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:

(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____
In this community _____ (Specify whether
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Phelps
(c) City or town Rolla
(If outside city or town limits write "RURAL")
(d) Street No. _____ (If rural, give location)
(e) If foreign born, how long in U. S. A. ? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept day 20
year 1940 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____;
that I last saw him _____ alive on _____, 19____;
and that death occurred on the date and hour stated above.

Immediate cause of death _____

Duration

Due to _____

Due to _____

Other conditions _____
(Include pregnancy within 3 months of death)

Major findings: _____
Of operations _____

Of autopsy _____

PHYSICIAN

Underline
the cause to
which death
should be
charged sta-
tistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) _____

(b) Date of occurrence _____

(c) Where did injury occur? _____
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place?

While at work? _____
(Specify type of place) (e) Means of injury _____

23. Signature E. E. Feind (M. D. or other) _____

Address Rolla Mo Date signed _____

3. (a) PRINT FULL NAME August Price

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex m 5. Color or race W 6. (a) Single, widowed, married, divorced married

6. (b) Name of husband or wife _____ 6. (c) Age of husband, or wife, if alive _____ years

7. Birth date of deceased _____
(Month) (Day) (Year)

8. AGE: Years 54 Months 10 Days 9 If less than one day _____ hr. _____ min.

9. Birthplace _____
(City, town, or county) (State or foreign country)

10. Usual occupation Farming

11. Industry or business _____

12. Name _____

13. Birthplace _____
(City, town, or county) (State or foreign country)

14. Maiden name _____

15. Birthplace _____
(City, town, or county) (State or foreign country)

16. (a) Informant _____

(b) Address _____

17. (a) _____ (b) Date thereof _____
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) Feb. 6, 1941 (b) Joe F. Myers
(Date received local registrar) (Registrar's signature)

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

MOTHER FATHERS

SUPPLEMENTARY

