

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-005324
STATE FILE NUMBER

FILED FEB 24 1959 Registration District No. 137 Primary Registration District No. Registrar's No. 40

1. PLACE OF DEATH a. COUNTY <u>Henry</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Cassden</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>WINDSOR</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>Climax Springs</u> c150 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>WINDSOR Hosp.</u>		Length of stay in 1b <u>3 days</u>	d. STREET ADDRESS (If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First Middle Last <u>Joseph FRANKLIN PRICE</u>			4. DATE OF DEATH Month Day Year <u>Feb 13 1959</u>			
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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>Jan 20, 1877</u>	9. AGE (In years last birthday) <u>82</u>	IF UNDER 1 YEAR Months Days <u>0 23</u>	IF UNDER 24 HRS. Hours Min. <u>45 00</u>
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Flouring</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>Ret Farmer</u>	11. BIRTHPLACE (City and state or country) <u>Deut Co, Iowa</u>	12. CITIZEN OF WHAT COUNTRY? <u>U. S. A</u>
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13a. FATHER'S NAME <u>John Price</u>	13b. MOTHER'S MAIDEN NAME <u>Unknown</u>	14. NAME OF HUSBAND OR WIFE <u>Grace Price</u>
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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>None</u>	17. INFORMANT Address <u>Grace Price Climax Springs, Mo</u>
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <u>IMMEDIATE CAUSE (b) mesenteric Thrombosis</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. <u>(a) Acute circulatory failure</u> <u>(c) Generalized arteriosclerosis</u>		INTERVAL BETWEEN ONSET AND DEATH <u>4 days</u> <u>4 days</u> <u>10 yrs</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH (but not related to the terminal disease condition given in PART I (a)) <u>4500</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" 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 Month, Day, Year a.m. p.m.	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>2/9/59</u> to <u>2/13/59</u> and last saw her alive on <u>2/13/59</u> Death occurred at <u>5:20 A. m</u> on the date stated above; and to the best of my knowledge, from the causes stated.	
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22a. SIGNATURE <u>Karl W. Cassden M.D.</u> (Degree or title)	22b. ADDRESS <u>114 N. Main, Windsor, Mo</u>	22c. DATE SIGNED <u>2/13/59</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>Feb 15, 1959</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Parkson Cemetery</u>	23d. LOCATION (City, town, or county) (State) <u>Quinn's Mills Morgan Co. Mo</u>
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24. FUNERAL DIRECTOR <u>John F. Reser</u>	ADDRESS <u>Warsaw</u>	25. DATE RECD. BY LOCAL REG. <u>2-16-59</u>	26. REGISTRAR'S SIGNATURE <u>Mildred Bigum</u>
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(Licensed Embalmer's Statement on Reverse Side)

300
1-57 0

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

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 *John F. Reser*

Licensed Embalmer No. *4098*

P. O. Address *Warsaw*

- 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.