

Health,  
& Welfare  
Public  
Service

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

59-022428  
STATE FILE NUMBER

FILED JUL 1 1959 Registration District No. 278 Primary Registration District No. 3054 Registrar's No. 87

S. 300  
1.-57

1. PLACE OF DEATH a. COUNTY <b>PIKE</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MISSOURI</b> b. COUNTY <b>PIKE</b>	
b. CITY OR TOWN <b>LOUISIANA</b>		c. CITY OR TOWN <b>BOWLING GREEN</b>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>PIKE COUNTY HOSPITAL</b>		d. STREET ADDRESS <b>1410 W. MAIN ST</b>	
Length of stay in lb <b>28 DAYS</b>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First <b>JAMES</b> Middle <b>ROY</b> Last <b>PRICE</b>			4. DATE OF DEATH Month <b>JUNE</b> Day <b>16</b> Year <b>1959</b>		
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>JULY 14, 1881</b>	9. AGE (In years last birthday) <b>77</b>	IF UNDER 1 YEAR Months <b>7</b> Days <b>7</b> Hours <b>7</b> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>DAIRYMAN - FARMER</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>PIKE CO. MISSOURI</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	

13a. FATHER'S NAME <b>JOHN HENRY PRICE</b>		13b. MOTHER'S MAIDEN NAME <b>MALISSA THURMOND</b>		14. NAME OF HUSBAND OR WIFE <b>EMILY JANE PRICE</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>NO 486-42-0993</b>		17. INFORMANT <b>MRS. W.M. WOOD JR. BOWLING GREEN MO</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>Carcinoma Stomach</b> <b>CARCINOMA STOMACH.</b>		INTERVAL BETWEEN ONSET AND DEATH <b>3 MONTHS</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____		

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>151X</b>		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.)	
20c. TIME OF INJURY Hour _____ a.m. _____ p.m.		

20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE 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>CLARKSVILLE</b>	COUNTY <b>MISSOURI</b>	STATE
21. I attended the deceased from <b>May 20 '59</b> to <b>June 16 '59</b> and last saw her/him alive on <b>June 16 '59</b> Death occurred at _____ m on the date stated above; and to the best of my knowledge, from the causes stated.				

22a. SIGNATURE <b>Dr. Bilyea</b>	(Degree or title) <b>2</b>	22b. ADDRESS <b>Louisiana</b>	22c. DATE SIGNED <b>6/21/59</b>
-------------------------------------	----------------------------	----------------------------------	------------------------------------

23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	23b. DATE <b>JUNE 18, 1959</b>	23c. NAME OF CEMETERY OR CREMATORY <b>GREENWOOD CEMETERY</b>	23d. LOCATION (City, town, or county) (State) <b>CLARKSVILLE MISSOURI</b>
24. FUNERAL DIRECTOR <b>GRACE BANKHEAD</b>		ADDRESS <b>BOWLING GREEN MO</b>	25. DATE RECD. BY LOCAL REG. <b>June 24 - 59</b>
26. REGISTRAR'S SIGNATURE <b>Bernice Collier</b>			

(Licensed Embalmer 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

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 *Harold C. Kirk* .....

Licensed Embalmer No. *4577* .....

P. O. Address *Cambridge Mass* .....

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.