

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-030510

STATE FILE NUMBER

Registration District No. 316 Primary Registration District No. --- Registrar's No. 319

FILED AUG 23 1961

DATE AMENDED

INSTEAD OF

BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY St. Francois		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Cape Girardeau	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Francois Township		Length of stay in 1b 2 Mos.; 20 days.	c. CITY OR TOWN Jackson
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION State Hospital No. 4		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	d. STREET ADDRESS (If outside, give location) Route 1
Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>			

3. NAME OF DECEASED (Type or print) First CIARENCE Middle R. Last PRICE	4. DATE OF DEATH Month July Day 30 Year 1961
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5. SEX Male	6. COLOR OR RACE White	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH Sept. 4, 1887	9. AGE (last birthday) 73	IF UNDER 1 YEAR Months 10 Days 26	IF UNDER 24 HR Hours --- Min. ---
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farming	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) Salem, Missouri	12. CITIZEN OF WHAT COUNTRY U.S.A.
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13a. FATHER'S NAME William Price	13b. MOTHER'S MAIDEN NAME Addie	14. NAME OF HUSBAND OR WIFE Nellie Martin Price
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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) No	16. SOCIAL SECURITY NO.	17. INFORMANT Mo. Records, State Hospital No. 4, Farmington, /	Address
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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: IMMEDIATE CAUSE (a) Arteriosclerosis, generalized and marked - - -		INTERVAL BETWEEN ONSET AND DEATH 2 years.
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) Chronic brain syndrome associated with cerebral arteriosclerosis/ with psychotic reaction.		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 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 _____ a.m. _____ p.m.	Month, Day, Year
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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 **May 10, 1961** to **July 30, 1961** and last saw ^{xxx}him live on **July 30, 1961**
Death occurred at **7:45 P. M.** on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <i>Lo F - Hunter</i> (Degree or title) 2nd	22b. ADDRESS State Hospital No. 4 Farmington, Missouri	22c. DATE SIGNED 8-1-61
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23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE Aug. 2, 1961	23c. NAME OF CEMETERY OR CREMATORY Memorial Park Cemetery Cape Girardeau, Mo. - Rural Route	23d. LOCATION (City, town, or county) (State)
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24. FUNERAL DIRECTOR Cracraft-Miller, Jackson, Missouri	ADDRESS	25. DATE RECD. BY LOCAL REG. aug 2, 1961	26. REGISTRAR'S SIGNATURE <i>Ether Rudloff</i>
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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 *Henry P. Cawright*

Licensed Embalmer No. 4327

P. O. Address Jackson, Mo.

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.