MAR 21 1929

14
3
7

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

Do not use this space.

5680

1. PLACE OF DEATH
County Callaway — Registration District No. 104 — File No.
Township — Primary Registration District No. 3008 — Registered No. 41
City Fulton (No. ..... St. ..... Ward)

2. FULL NAME William Price
(a) Residence. No. ..... St., ... Ward. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred 3 yrs. — mos. — ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: Black
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word): Unknown

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF: Unknown

6. DATE OF BIRTH (MONTH, DAY AND YEAR): OK

7. AGE: 22 YEARS — MONTHS — DAYS — If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Laborer
(b) General nature of industry, business, or establishment in which employed (or employer): —
(c) Name of employer: —

9. BIRTHPLACE (CITY OR TOWN): —
(STATE OR COUNTRY): —

PARENTS
10. NAME OF FATHER: Unknown
11. BIRTHPLACE OF FATHER (CITY OR TOWN): —
(STATE OR COUNTRY): —
12. MAIDEN NAME OF MOTHER: —
13. BIRTHPLACE OF MOTHER (CITY OR TOWN): —
(STATE OR COUNTRY): —

14. INFORMANT: Med Certificate
(Address)

15. FILED Feb 9 1929 R. N. Creus
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR): 2/9/1929

17. I HEREBY CERTIFY, That I attended deceased from Sept 1929, to Feb 9 1929 that I last saw h[illegible] alive on Feb 9 1929 and that death occurred, on the date stated above, at 8 a.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Acute Dilatation of Heart.
(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (SECONDARY): 1010
(duration) ..... yrs. ..... mos. ..... ds.

18. WHERE WAS DISEASE CONTRACTED IF NOT AT PLACE OF DEATH? —
DID AN OPERATION PRECEDE DEATH? No DATE OF —
WAS THERE AN AUTOPSY? No
WHAT TEST CONFIRMED DIAGNOSIS? Clinical
(Signed) E. E. Gay M. D.
, 19 (Address) State Hospital

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

Fulton Mo

19. PLACE OF BURIAL, CREMATION, OR REMOVAL: Kirksville, Mo — DATE OF BURIAL: 2-11 1929

20. UNDERTAKER: Eli Bell — ADDRESS: Fulton Mo

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

237
31
33
33