

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

Do not use this space.

12092

1. PLACE OF DEATH

County Cole
Township _____
City Jefferson City (No. _____)

Registration District No. 213
Primary Registration District No. 3014

File No. _____
Registered No. 106 St. _____ Ward _____

2. FULL NAME Jack 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, 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 White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Married

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Mr. Jack Price

6. DATE OF BIRTH (MONTH, DAY AND YEAR) July 14th, 1904

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
25 8 26

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work _____
(b) General nature of industry, business, or establishment in which employed (or employer) _____
(c) Name of employer _____

9. BIRTHPLACE (CITY OR TOWN) Ohio
(STATE OR COUNTRY)

10. NAME OF FATHER _____
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 Miss State Prison
(Address) Mo. Pr.

15. FILED 5/10/30 S. V. Bedford REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) April 9th, 1930

17. I HEREBY CERTIFY, That I attended deceased from 4-6 1930, to 4-9 1930.
that I last saw him alive on 4-9 1930, and that death occurred, on the date stated above, at 6:30 P. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Meningitis. Pneumococcus.
79A

(duration) yrs. mos. 4 ds.

CONTRIBUTORY (SECONDARY) none

(duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED none

IF NOT AT PLACE OF DEATH _____

19. DID AN OPERATION PRECEDE DEATH? no DATE OF _____

WAS THERE AN AUTOPSY? no
WHAT TEST CONFIRMED DIAGNOSIS? Spinal fluid.
(Signed) D. G. Gillham M. D.

4/10, 1930. (Address) Jefferson City Mo

*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.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL Kirksville Mo DATE OF BURIAL 4-11 1930

20. UNDERTAKER Chas. P. Heinicke ADDRESS J. C. Mo.

WRITE PLAINLY, WITH UNFADING INK---THIS IS A PERMANENT RECORD

K. 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.

MAY 23 1930

13/10
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6
4
107
60
167