

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

3520
Do not use this space.

1. PLACE OF DEATH
 (a) County Reynolds Registration District No. 1108
 (b) Township West Primary Registration District No. 5
 (c) City Garwood Village or Garwood (d) Street No. _____ St.
 (If death occurred in Hospital or Institution, write its name instead of street and number)
 (e) Length of residence in city or town where death occurred
 yrs. mos. ds. (f) How long in U.S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME James Wiley Price
 (a) Residence, No. 670 Garwood, Mo. St. (If nonresident, give city or town and State)
 (Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M 4. COLOR OR RACE W. 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) widowed

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Mary (Polly) Price

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Feb 27 1855

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
55 18 55 11 27

OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Farmer
 9. Industry or business in which work was done, as saw mill, bank, etc.
 10. Date deceased last worked at this occupation (month and year) 1925 11. Total time (years) spent in this occupation all life

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Ky.

FATHER 13. NAME James Price

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) N. Carolina

MOTHER 15. MAIDEN NAME Thelithy Price

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) 12 Kentucky

17. INFORMANT (ADDRESS) Don Price, Garwood, Mo.

18. BURIAL, CREMATION, OR REMOVAL PLACE Odell Cem. DATE Feb. 3rd 1940

19. FUNERAL DIRECTOR (NAME) (ADDRESS) Carl Martin, Garwood, Mo.

20. FILED _____ 19 _____ Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Feb. 2, 1940

22. I HEREBY CERTIFY, That I attended deceased from Jan. 31st 1940 to Feb. 2, 1940
 I last saw him alive on Feb. 2nd 1940 Death is said to have occurred on the date stated above, at 4 a.m.
 The principal cause of death and related causes of importance were as follows:
Flu

Date of onset 1-31-40

Other contributory causes of importance:
Infirmities of age

Name of operation _____ Date of _____
 What test confirmed diagnosis? _____ Was there an autopsy? _____

23. If death was due to external causes (violence), fill in also the following:
 Accident, suicide, or homicide? _____ Date of injury _____, 19 _____
 Where did injury occur? _____ (Specify city or town, county, and State)
 Specify whether injury occurred in industry, in home, or in public place. _____

Manner of injury _____
 Nature of injury _____

24. Was disease or injury in any way related to occupation of deceased? _____
 If so, specify _____
 (Signed) J. W. Cotton, M. D.
Van Buren Mo
 (Address) _____

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

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.

1 X16805

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.....

....., Registered Apprentice No.....

working under my personal supervision.

RECEIVED

District Health Officer No. 5,

District File Number 240198

Date Filed 21440

Signed.....

Licensed Embalmer No.....

P. O. Address.....

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 this body is not embalmed, above space should be left blank.

FILED JUL 15 1940

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 35-20

Registration District No. 1108

Primary Registration District No. 3985-

Registrar's No. 2

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH:

(a) County Reynolds
(b) City or town Webb sup
(c) Name of hospital or institution:
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution
In this community (Specify whether years, months or days)

3. (a) PRINT FULL NAME James Wiley Price

3. (b) If veteran, name war
3. (c) Social Security No.

4. Sex m 5. Color or race w 6. (a) Single, widowed, married divorced wd

6. (b) Name of husband or wife
6. (c) Age of husband, or wife, if alive 185 years

7. Birth date of deceased Nov 27 (Month) (Day) (Year)

| 8. AGE: | Years | Months | Days | If less than one day |
|---------|-------|--------|------|----------------------|
| 86 | | 2 | 20 | hr min |

9. Birthplace (City, town, or county) (State or foreign country)

10. Usual occupation

11. Industry or business

12. Name

13. Birthplace (City, town, or county) (State or foreign country)

14. Maiden name (City, town, or county) (State or foreign country)

15. Birthplace (City, town, or county) (State or foreign country)

16. (a) Informant

(b) Address

17. (a) (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)

(c) Place: burial or cremation

18. (a) Signature of funeral director

(b) Address

19. (a) Date received local registrar (b) Registrar's signature

2. USUAL RESIDENCE OF DECEASED:

(a) State (b) County
(c) City or town (If outside city or town limits write "RURAL")
(d) Street No. (If rural, give location)
(e) If foreign born, how long in U. S. A. ? years

MEDICAL CERTIFICATION

20. DATE OF DEATH Month Feb day 2 year 1940 hour minute M.

21. I hereby certify that I attended the deceased from 19 to 19 that I last saw him alive on and that death occurred on the date and hour stated above.

Immediate cause of death

Due to

Due to

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations

Of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify)

(b) Date of occurrence

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place?

While at work? (Specify type of place) (e) Means of injury

23. Signature J. W. Cotton (M. D. or other)

Address Van Buren Mo Date signed

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

SUPPLEMENTAL

MAY 17 1940

S-3520

1940

1940

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1940