FILED JUN 17 1940

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 17682

Registration District No. 399 Primary Registration District No. 1002 Registrar's No. 2209

1. PLACE OF DEATH:

(a) County Jackson

(b) City or town Kansas City (If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: General Hospital #2 (If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 5-23-40-5-27-40 (Specify whether

In this community 15 years years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County Jackson

(c) City or town Kansas City (If outside city or town limits, write "RURAL")

(d) Street No. 2927 Jarboe (If rural, give location)

(e) If foreign born, how long in U. S. A.? ..... years.

3. (a) PRINT FULL NAME Robert Price 620

3. (b) If veteran, name war No

3. (c) Social Security No. No

4. Sex Male

5. Color or race Negro

6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Luella Price

6. (c) Age of husband or wife if alive Unknown years

7. Birth date of deceased 10 (Month) 22 (Day) 1866 (Year)

8. AGE: Years 63 Months 7 Days 5 If less than one day ..... hr. ..... min.

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

10. Usual occupation none

11. Industry or business

FATHER
12. Name Payne Price
13. Birthplace Unknown (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name Adrene Charleston
15. Birthplace Magnolia (City, town, or county) Miss. (State or foreign country)

16. (a) Informant's own signature Record Clerk

(b) Address Gen. Hosp. #2

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 5-30-40 (Month) (Day) (Year)

(c) Place: burial or cremation West Lawn

18. (a) Signature of funeral director K. C. Emb. & Casket Co. Mrs. J. W. Jones

(b) Address 440 State Ave.

19. (a) Mar 29, 1940 (Date received local registrar) (b) M. M. Crowe (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 5 day 27 year 40 hour 6 minute A. M.

21. I hereby certify that I attended the deceased from 5-23-, 1940 to 5-27-, 1940 that I last saw him alive on 5-27-, 1940 and that death occurred on the date and hour stated above.

Immediate cause of death Uremia (Clinically)

Due to Arterio-Vascular Nephritis.

Due to

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Other conditions (Include pregnancy within 3 months of death)

Major findings:
Of operations

Of autopsy Above Mentioned

Duration

PHYSICIAN — Underline the cause to which death should be charged statistically

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? (Specify type of place)

While at work? (e) Means of injury

23. Signature G. C. Crowe (M. D. or other)

Address General Hospital #2 Date signed 5-27

(Licensed Embalmer's Statement on Reverse Side)

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.

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 Eugene English, Registered Apprentice No. ..... working under my personal supervision.

Signed Eugene English

Licensed Embalmer No. 4105

P. O. Address K. C. Kansas

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply wit the above constitutes grounds for revocation of license.)

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