

FILED JAN 10 1944

Registration District No. **184**

Primary Registration District No. **3038**

1. PLACE OF DEATH:

(a) County **Linn**
(b) City or town **Brookfield**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: **1531 S Clinton**
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution. **1 month** (Specify whether years, months or days)
In this community **1 month** (Specify whether years, months or days)

3. (a) PRINT FULL NAME **VIRGINIA-ALINE PRICE**

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

4. Sex **F** 5. Color or race **W** 6. (a) Single, widowed, married, divorced **Single**

6. (b) Name of husband or wife. 6. (c) Age of husband or wife if alive **29** years (Day) (Year)

7. Birth date of deceased **October 29 1943**
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
— 1 4 hr. min.

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

10. Usual occupation.

11. Industry or business.

MOTHER FATHER
12. Name **Orlando Price**
13. Birthplace **Wheeling Mo**
(City, town, or county) (State or foreign country)
14. Maiden name **Lela Melvina Leaton**
15. Birthplace **Brookfield - MO**
(City, town, or county) (State or foreign country)

16. (a) Informant **Orlando Price**
(b) Address **Brookfield - Mo**
17. (a) **Burial** (Burial, cremation, or removal) (b) Date thereof **Dec. 5 '43**
(Month) (Day) (Year)
(c) Place: burial or cremation **Rose Hill - Brookfield Mo**

18. (a) Signature of funeral director **Hill Chapel**
(b) Address **Brookfield**
19. (a) **12-4-1943** (Date received local registrar) (b) **W W Canam** (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **Linn**
(c) City or town **Brookfield**
(If outside city or town limits, write "RURAL")
(d) Street No. **531 S Clinton**
(If rural, give location)
(e) Citizen of foreign country? **No** (Yes or No)
If yes, name country.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Dec.** day **3**
year **1943** hour **1:00** minute **P.** M.

21. I hereby certify that I attended the deceased from **Dec 1** 1943 to **Dec 3** 1943
that I last saw her alive on **Dec 3** 1943
and that death occurred on the date and hour stated above.

Immediate cause of death **Pneumonia** Duration **12-1-43**

Due to
Due to

Other conditions (Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy

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?

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

23. Signature **Wm F. Lamance** (M.D. or other) **D.O.**
Address **Brookfield, Mo** Date signed **12-4-43**

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

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.

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, fact should be so stated above.

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. Jan.
Registrar's No. _____

Registration District No. _____ Primary Registration District No. _____

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

1. PLACE OF DEATH:

(a) County Lincoln
(b) City or town Brookfield
(If outside city or town limits, write "RURAL" and name of township)
(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. _____ (Specify whether

In this community _____ years, months or days) (Specify whether

3. (a) PRINT FULL NAME Virginia A. Price

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

4. Sex 7 5. Color or race W 6. (a) Single, widowed, married, divorced 2

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

7. Birth date of deceased Oct. 29 - 1943
(Month) (Day) (Year)

8. AGE: Years _____ Months _____ Days _____ If less than one day _____ 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 _____

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

16. (a) Informant _____ (b) Address _____

17. (a) _____ (b) Date thereof _____ (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____ (b) Address _____

19. (a) _____ (b) _____ (Date received local registrar) (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) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec year 1943 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____ 19____; that I last saw him/her alive on _____ 19____; and that death occurred on the date and hour stated above. Immediate cause of death _____

Pneumonia
Lobar Pneumonia
Due to _____
Due to no other complicating diseases
Other conditions _____ (include pregnancy within 3 months of death)

Major findings: Of operations _____ 108
Of autopsy _____

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? _____

While at work? _____ (Specify type of place) (e) Means of Injury _____
23. Signature Mrs J. L. Price (M. D. or other) DO.
Address Brookfield, Mo Date signed 1-14-44

SUPPLEMENTARY

S-42843