

FILED DEC 17 1943
Registration District No. 289

Primary Registration District No. 3043

1. PLACE OF DEATH:

(a) County Marion
(b) City or town Harrisburg
(c) Name of hospital or institution: Leveing Hosp. O
(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

2. USUAL RESIDENCE OF DECEASED:

(a) State MO (b) County Marion 64
(c) City or town Harrisburg 3
(If outside city or town limits, write "RURAL")
(d) Street No. 608 Fulton Ave 4
(If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME Martha E. Price

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

4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced Single

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

7. Birth date of deceased Dec. 14, 1928
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
15 10 18 hr. min.

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

10. Usual occupation Student

11. Industry or business _____

12. Name James Price

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

14. Maiden name Lora Waggoner

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

16. (a) Informant Mrs. Lora Waggoner

(b) Address 608 Fulton Harrisburg Mo

17. (a) Burial (b) Date thereof 11-4-43
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Grandview Burial Park

18. (a) Signature of funeral director James O'Connell

(b) Address Harrisburg Mo

19. (a) 11-8-43 (b) R W Connor
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month NOV. day 2nd
year 1943 hour _____ minute 6:50 A.M.

21. I hereby certify that I attended the deceased from Oct-1 43
to Nov 2 43
that I last saw her alive on Oct 29 1943
and that death occurred on the date and hour stated above.

Immediate cause of death Congestive heart failure Duration 6 mo

Due to myocard stenosis 12%

Due to Pneumonia at age 3

Other conditions _____
(Include pregnancy within 5 months of death)

Major findings: 59%
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) (e) Means of injury _____

23. Signature R W Connor (M.D. or other) _____
Address Harrisburg Mo Date signed 11-4-43

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

4
3
4

MOTHER FATHER

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 Michael J. O'Donnell

Licensed Embalmer No. 3246

P. O. Address Hannibal Mo

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.