

FILED FEB 14 1944

Registration District No. 2

Primary Registration District No. 4009

Registrar's No. 7

1. PLACE OF DEATH:

(a) County Andrew  
(b) City or town Darwin, Mo.  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
St. Michael's Hospital  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 9 days  
(Specify whether  
In this community yes  
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Andrew  
(c) City or town Bakersfield, Mo.  
(If outside city or town limits, write "RURAL")  
(d) Street No. \_\_\_\_\_  
(If rural, give location)  
(e) Citizen of foreign country? no (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME JAMES RUBEN PRICE

3. (b) If veteran, name war no  
3. (c) Social Security No. none

4. Sex male 5. Color or race white  
6. (a) Single, widowed, married, divorced 1  
6. (b) Name of husband or wife Dora Price  
6. (c) Age of husband or wife if alive 66 years  
7. Birth date of deceased November 4 1871  
(Month) (Day) (Year)

8. AGE: Years 72 Months 2 Days 23  
If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

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

10. Usual occupation none

11. Industry or business \_\_\_\_\_

MOTHER FATHER { 12. Name Unknown  
13. Birthplace Unknown (City, town, or county) (State or foreign country) 9  
14. Maiden name Unknown  
15. Birthplace Unknown (City, town, or county) (State or foreign country) 9

16. (a) Informant Floyd Price  
(b) Address Elidah, Mo.

17. (a) Removal (b) Date thereof 1-28-44  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation West Plains, Missou

18. (a) Signature of funeral director Halter Meierhoffer

(b) Address Box 2 Argon St. St. Louis, Mo.

19. (a) 1-28-44 (b) F.H. Fitchman  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan. day 27  
year 1944 hour 2 minute 15 P.M.

21. I hereby certify that I attended the deceased from Jan. 19 1944 to Jan. 27 1944  
that I last saw him alive on Jan 27-44 1944  
and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral Hemorrhage 3 days

Due to Hypertension (Essential) unknown

Due to Chronic nephritis

Other conditions Carcinoma Right side 7 months  
(Include pregnancy within 3 months of death) Empyema face

Major findings: Carcinoma face

Of operations \_\_\_\_\_  
Of autopsy not made 3

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 0

23. Signature Floyd H. Fitchman (M. D. certified) 1  
Address Darwin, Mo. Date signed 1-27-44

Duration  
3 days  
7 months  
PHYSICIAN  
Underline the cause to which death should be charged statistically.

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

1012

**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

*Albert P. Harrington*

Licensed Embalmer No. *3258 Mo.*

P. O. Address. *St. Joseph, Mo.*

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

**If this body is not embalmed, fact should be so stated above.**