

FILED MAR 14 1944

STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No.

8108

Registration District No.

297

Primary Registration District No.

44466020

Registrar's No.

4

## 1. PLACE OF DEATH:

(a) County Ray  
 (b) City or town Ray Rural R-2  
 (If outside city or town limits, write "RURAL" and name of township)  
 (c) Name of hospital or institution: Ray  
 (If not in hospital or institution, write street number or location)  
 (d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether)  
 In this community 16 years  
 years, months or days

## 3. (a) PRINT FULL NAME

Lillian Belle Price3. (b) If veteran,  
name war \_\_\_\_\_3. (c) Social Security  
No. \_\_\_\_\_

4. Sex female / race White / 5. Color or race White  
 6. (a) Single, widowed, married, divorced married  
 6. (b) Name of husband or wife George Price 6. (c) Age of husband or wife if  
 alive 66 years  
 7. Birth date of deceased Oct - 16 - 1892  
 (Month) (Day) (Year)

8. AGE: Years Months Days If less than one day  
52 4 24 hr. min.

9. Birthplace Illinois (City, town, or county) (State or foreign country)10. Usual occupation Housekeeper

## 11. Industry or business

12. Name John R Beckard  
 13. Birthplace Ill (City, town, or county) (State or foreign country)  
 14. Maiden name Bert Knorr  
 15. Birthplace unknown (City, town, or county) (State or foreign country)

16. (a) Informant Mary Mc Kinnack  
 (b) Address Springy Oaks R 1  
 17. (a) Hardin (b) Date thereof Feb 12 44  
 (Burial, cremation, etc.) (Month) (Day) (Year)  
 (c) Place: burial or cremation Hardin Cem

18. (a) Signature of funeral director John W. Kimpich  
 (b) Address Hardin Mo.  
 19. (a) 2/11/44 (b) Mrs. Chas. W. Sheppard  
 (Date received local registrar) (Registrar's signature)

## 2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Ray  
 (c) City or town Hardin - Rural  
 (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 \_\_\_\_\_

## MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb day 10  
 year 1944 hour 12 minute 02 - A.M.

21. I hereby certify that I attended the deceased from Feb 6  
 1944, to Feb 10 1944

that I last saw her alive on Feb 9 1944  
 and that death occurred on the date and hour stated above.

Immediate cause of death Peritonitis Duration 1 day

Due to Infective Left Kidney  
Probably stones - acute 3 days  
 Due to Pyelitis

Other conditions  
 (Include pregnancy within 3 months of death)

Major findings:  
 Of operations: 134

Of autopsy \_\_\_\_\_

## PHYSICIAN

Underline  
 the cause to  
 which death  
 should be  
 charged sta-  
 tistically.

## 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 0

23. Signature Mary Mc Kinnack (M. D. or other)  
 Address Hardin Mo. Date signed 2/11/1944

RECEIVED

District Health Officer No. 8,

District File Number

Date Filed

3-13-44

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 *MO*

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

Signature *John W. Kripochild*

Licensed Embalmer No. *2789*

P. O. Address *Harden 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.

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. March

Registration District No. 297

Primary Registration District No. 4446, 6020

Registrar's No. 4

1. PLACE OF DEATH:

(a) County Ray  
(b) City or town Ray, HARDIN MO  
(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)

3. (a) PRINT FULL NAME Lillian B. Price

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

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

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

7. Birth date of deceased Oct 16 (Month) (Day) (Year)

8. AGE: Years 5 Months 4 Days 22 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)  
(Burial, cremation, or removal)

(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 Feb 1945 year. Hour \_\_\_\_\_ minute \_\_\_\_\_ M.

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

Duration

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) (e) Means of injury \_\_\_\_\_

23. Signature \_\_\_\_\_ (M. D. or other) \_\_\_\_\_

Address \_\_\_\_\_ Date signed \_\_\_\_\_

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

SUPPLEMENTARY

8108