

FILED MAR 20 1945  
Registration District No. 31845

Primary Registration District No. 3006

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

1. PLACE OF DEATH:

(a) County Boone

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

(c) Name of hospital or institution: Hatewood Convalescent Home  
(If not in hospital or institution, write street number or location) 4

(d) Length of stay: In hospital or institution 4  
years, months or days (Specify whether)

In this community about 3 mo.  
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Boone <sup>10</sup>

(c) City or town Columbia <sup>4</sup>  
(If outside city or town limits, write "RURAL")

(d) Street No. 1042 1/2 Oak St.  
(If rural, give location)

(e) Citizen of foreign country? No. (Yes or No)

If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME ABRAHAM PRICE

3. (b) If veteran, name war \_\_\_\_\_

3. (c) Social Security No. none

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 12 day 22  
year 1944 hour 3 minute 15 A.M.

21. I hereby certify that I attended the deceased from Nov 10, 1944, to Nov 22, 1945  
and that death occurred on the day and hour stated above.

4. Sex Male

5. Color or race negro

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

6. (b) Name of husband or wife \_\_\_\_\_

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

7. Birth date of deceased unknown  
(Month) (Day) (Year)

Immediate cause of death Chronic myocarditis

Duration 1 yr

8. AGE: Years about 85 Months \_\_\_\_\_ Days \_\_\_\_\_ If less than one day hr. \_\_\_\_\_ min. \_\_\_\_\_

Due to Hypertension & arteriosclerosis

Due to \_\_\_\_\_

9. Birthplace Randolph Co. Mo.  
(City, town, or county) (State or foreign country)

Other conditions none  
(Include pregnancy within 3 months of death)

10. Usual occupation none

Major findings: no op. of 30

Of operations \_\_\_\_\_

Of autopsy none

PHYSICIAN \_\_\_\_\_

Underline the cause to which death should be charged statistically.

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

12. Name unknown

13. Birthplace \_\_\_\_\_  
(City, town, or county) (State or foreign country)

14. Maiden name unknown

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

16. (a) Informant Institution record

(b) Address Columbia Mo.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-5-1945  
(Month) (Day) (Year)

(c) Place: burial or cremation Mo. Medical School

18. (a) Signature of funeral director Stuart H. Parker

(b) Address Columbia Missouri

19. (a) 2-7-45 (Date received local registrar) (b) Edna H. Barber (Registrar's signature)

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 Al Kampchmidt (M. D. or other) <sup>10</sup>

Address Columbia Mo Date signed 1-30-45

1250

RECEIVED

District Health Officer, No. 9,

District File Number \_\_\_\_\_

Date Filed 3-19-45

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed <sup>not</sup> by me, or by \_\_\_\_\_

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

Signed \_\_\_\_\_

*Stuart P. Parker*

Licensed Embalmer No. \_\_\_\_\_

*2900*

P. O. Address \_\_\_\_\_

*Columbia 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.**