

FILED MAY 12 1945 **318**

Registration District No. _____ Primary Registration District No. **1003**

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

1. PLACE OF DEATH:

(a) County _____
(b) City or town St. Louis
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
Alexian Bros. Hospital
(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 James Henry Price

3. (b) If veteran, name war Nil 3. (c) Social Security No. None

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

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

7. Birth date of deceased April 7 1861
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
84 0 20 hr. min.

9. Birthplace Unknown Ohio
(City, town, or county) (State or foreign country)

10. Usual occupation Farmer

11. Industry or business _____

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

16. (a) Informant D. E. Price
(b) Address 457 N. 25th, East St. Louis

17. (a) Burial (b) Date thereof 4-30-45
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Caledonia, Missouri

18. (a) Signature of funeral director Albert H. Hoppe

(b) Address 4700 Washington Blvd.

19. (a) MAY 1 1945 (b) J. F. Bredek
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Iron 47
(c) City or town Bellevue
(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 April day 27
year 1945 hour 5:00 minute A. M.

21. I hereby certify that I attended the deceased from September 10, 1938 to April 27, 1945
that I last saw him alive on April 25, 1945
and that death occurred on the date and hour stated above.

Immediate cause of death Bronchial Pneumonia Duration 3 days
Due to Streptococcus Sore Throat 10 day
Contributing cause Senility and Dehydration

Other conditions (Include pregnancy within 3 months of death) _____

Major findings: Of operations _____ Of autopsy _____
PHYSICIAN 115
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? _____
(d) Did injury occur in or about home, on farm, industrial place, in public place?
60 N. 1st St. MO
While at work? _____ (Specify type of place) (e) Means of injury _____

23. Signature B. A. Nester (M. D. or other) MO
Address 4439 Bates St. Date signed 4-30-45

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..... *E. W. Wilkinson*

Licensed Embalmer No..... *3575*

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.