

Registration District No. **47** Primary Registration District No. **3008**

14
1
2

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

1. PLACE OF DEATH

(a) County Calloway
 (b) City or town Fulton
 (c) Name of hospital or institution: State Hospital No 1
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution 10 yrs 1m 5d
 In this community 10 yrs 1m 5d (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson
 (c) City or town Kansas City **14**
 (If outside city or town limits, write "RURAL")
 (d) Street No. 1634 Washington **1**
 (If rural, give location)
 (e) Citizen of foreign country? no **2** (Yes or No)
 If yes, name country _____

3. (a) PRINT FULL NAME Olin Price

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 7 year 1945 hour 12-50 minute P M.

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

21. I hereby certify that I attended the deceased from 3-1-45 19 to 4-5- 19 45
 that I last saw him alive on 4-5- 19 45
 and that death occurred on the date and hour stated above.

4. Sex Female **5. Color of race** White **6. (a) Single, widowed, married, divorced** Married
6. (b) Name of husband or wife Ralph Diamond **6. (c) Age of husband or wife if alive** 58 years
7. Birth date of deceased Sept-26-1900
 (Month) (Day) (Year)

Immediate cause of death Myocarditis
 Due to Arteriosclerosis
 Due to _____
 Other conditions (include pregnancy within 3 months of death) _____
 Major findings: Of operations _____
 Of autopsy _____

8. AGE: Years 44 Months 6 Days 9 If less than one day _____ hr. _____ min.

9. Birthplace Vinitia Okla (City, town, or county) (State or foreign country)

10. Usual occupation Stenographer

11. Industry or business _____

MOTHER FATHER

12. Name James Price
13. Birthplace Indiana (City, town, or county) (State or foreign country)
14. Maiden name Anna M. Price
15. Birthplace Indiana (City, town, or county) (State or foreign country)

16. (a) Informant Record
 (b) Address _____

17. (a) Removal (b) Date thereof 4-6-1945
 (Burial, cremation, or removal) (Month) (Day) (Year)

18. (a) Signature of funeral director G. O. Daehler
 (b) Address 15th & Paseo, S.C.M.O.

19. (a) 4-6-1945 (b) Joan Morrison
 (Date received local registrar) (Registrar's signature)

PHYSICIAN
 Underline the cause to which death should be charged statistically.
ABE

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.P. Price (M. D. or other) M.D.
 Address Fulton Mo Date signed 4/6/45

RECEIVED

District Health Officer No. 9,

District File Number.....

Date Filed 5-9-45

MAR 2 1959

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 A P Doshler

Licensed Embalmer No. 1166

P. O. Address 1415 E 15th St

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.