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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED JUN 11 1945

Registration District No. 317

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

18219

State File No. 0

Primary Registration District No. 6076

Registrar's No. 1266

1. PLACE OF DEATH:

(a) County St. Louis

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

(c) Name of hospital or institution: Robert Koch Hospital (If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 1218 days (Specify whether

In this community Life years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County —

(c) City or town St. Louis (If outside city or town limits, write "RURAL")

(d) Street No. 2515A Hadley (If rural, give location)

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

If yes, name country —

3. (a) PRINT FULL NAME Oscar 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 Single

6. (b) Name of husband or wife —

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

7. Birth date of deceased January (Month) 27 (Day) 1926 (Year)

8. AGE: Years 19 Months 4 Days 4 If less than one day — hr. — min.

9. Birthplace St. Louis (City, town, or county) Missouri (State or foreign country)

10. Usual occupation Student

11. Industry or business —

FATHER
12. Name Oscar Price
13. Birthplace ? (City, town, or county) ? (State or foreign country)

MOTHER
14. Maiden name Katherine Wilson
15. Birthplace Versailles (City, town, or county) Missouri (State or foreign country)

16. (a) Informant Patients Hospital Record

(b) Address Robert Koch Hospital

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 6-4-45 (Month) (Day) (Year)

(c) Place: burial or cremation St Mathews Cem

18. (a) Signature of funeral director Ortmann Funeral Home

(b) Address 6222 Lackland Overland MO

19. (a) JUN 4 1945 (Date received local registrar) (b) E. B. McLaurin MD (Registrar's signature) BY

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 31 year 1945 hour 9 05 ~~minute~~ A M.

21. I hereby certify that I attended the deceased from January 13, 1945, to May 31, 1945, that I last saw him alive on May 31, 1945 and that death occurred on the date and hour stated above.

Immediate cause of death

Due to Electrocution 193

Due to Accident 40

Other conditions (Include pregnancy within 3 months of death)

Major findings:
Of operations

Of autopsy

Duration

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) Accident

(b) Date of occurrence May 31, 1945

(c) Where did injury occur? Koch (City or town) St. Louis (County) Mo. (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? Hospital (Specify type of place)

While at work? No (e) Means of injury —

23. Signature R. Engleman (M. D. ~~other~~)

Address Robert Koch Hospital Date signed 5/31/45

(Licensed Embalmer's Statement on Reverse Side)

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: Al C Ostmann

Licensed Embalmer No. 3478

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.