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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

FILED SEP 7 1945

State File No. 28697

Registration District No. 377 Primary Registration District No. 3075 Registrar's No. 25

1. PLACE OF DEATH:

(a) County Stoddard

(b) City or town Dexter (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)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Stoddard

(c) City or town Dexter (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

3. (a) PRINT FULL NAME JUDSON PRICE

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex Male

5. Color or race White

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

6. (b) Name of husband or wife Belle Price

6. (c) Age of husband or wife if alive 71 years

7. Birth date of deceased Oct. 8, 1870 (Month) (Day) (Year)

8. AGE: Years 74 Months 8 Days 23 If less than one day hr. min.

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

10. Usual occupation Retired

11. Industry or business

FATHER
12. Name No record
13. Birthplace No record (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name No record
15. Birthplace No record (City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Belle Price

(b) Address Dexter, Mo.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 7-2-45 (Month) (Day) (Year)

(c) Place: burial or cremation Dexter Cemetery

18. (a) Signature of funeral director Blankenship-Strickland

(b) Address Dexter, Mo.

19. (a) 8-31-45 (Date received local registrar) (b) Nora Smith (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 1 year 1945 hour 7 minute 55 P.M.

21. I hereby certify that I attended the deceased from JANUARY 12, 1945 to JULY 1, 1945; that I last saw him alive on JULY 1, 1945; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death ACUTE MYOCARDITIS	2 HOURS
Due to CHRONIC MYOCARDITIS	3 YEARS APPROX.
Due to WEAKENING HEART MUSCLE + FOCI OF INFECTION	
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? (Specify type of place)

While at work? (e) Means of injury 2

23. Signature Dr Harold C Poe (~~M. D. or other~~) D.O.

Address Dexter, Mo. Date signed 7/2/45

1134 (Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Office No. 2
District File Number 945-2983
Date Filed 9-5-45

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 [signature]

Licensed Embalmer No. 3479

P. O. Address Dexter, 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.