

FILED JAN 12 1946

Registration District No. 38

Primary Registration District No. 3006

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: Boone County Hospital
 (If not in hospital or institution, write street number & location)
 (d) Length of stay: In hospital or institution 2 hrs (Specify whether
 In this community about 3 yrs (Specify whether
 years, months or days)

3. (a) PRINT FULL NAME HOMER PRICE3. (b) If veteran,
name war _____3. (c) Social Security
No. 486-05-9948

4. Sex Male 5. Color or race negro
 6. (a) Single, widowed, married, divorced widowed
 6. (b) Name of husband or wife Zora Price 6. (c) Age of husband or wife if
 alive _____ years
 7. Birth date of deceased: 2-26-1890
 (Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
55 9 10 hr. _____ min.

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

10. Usual occupation Janitor11. Industry or business Truck & transfer Co.12. Name John Price13. Birthplace Unknown → 9
 (City, town, or county) (State or foreign country)14. Maiden name Mary Jones15. Birthplace Unknown → 9
 (City, town, or county) (State or foreign country)16. (a) Informant Mary Johnson(b) Address Kansas City, Mo.17. (a) Removal (b) Date thereof 12-9-1945
 (Burial, cremation, or removal) (Month) (Day) (Year)(c) Place: burial or cremation Richmond, Mo.18. (a) Signature of funeral director Stuart S. Parker(b) Address Columbia, Missouri19. (a) Dec 9, 1945 (b) Mrs R. E. Palmer
 (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Boone 10
 (c) City or town Columbia 2
 (If outside city or town limits, write "RURAL")
 (d) Street No. 101 N. 7th St. 4
 (If rural, give location) 0
 (e) Citizen of foreign country? No (Yes or No)
 If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec day 6
 year 1945 hour 2 minute PM

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____;
 that I last saw him _____ alive on _____, 19____,
 and that death occurred on the date and hour stated above.

Immediate cause of death Uremia /
 Duration _____

Due to _____

Due to _____

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

Major findings: _____
 Of operations _____

Of autopsy Uremia
 ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED BY 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 _____

23. Signature J. Edwards 3 Coroner
 (M.D. or other) _____Address Columbia, Mo Date signed 12-8-45

RECEIVED

District Health Officer No. 9,

District File Number.....

Date Filed 1-11-46

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

Stuart P. Parker

Licensed Embalmer No. 2900

P. O. Address Columbia, Md.

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.

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUSTHE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATHState File No. *Jan*Registrar's No. *314*Registration District No. *28*Primary Registration District No. *3086*

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:

(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 *Homer Price*

3. (b) If veteran, name war _____

3. (c) Social Security No. _____

4. Sex *M* 5. Color or race *B* 6. (a) Single, widowed, married, divorced *wid*

6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____

7. Birth date of deceased *Feb 26* (Month) (Day) (Year)8. AGE: Years *55* Months _____ Days _____ If less than one day _____ hr. _____ min.9. Birthplace _____ (City, town, or county) (State or foreign country) *Mo*

10. Usual occupation _____

11. Industry or business _____

12. Name _____

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

14. Maiden name _____

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

16. (a) Informant _____

(b) Address _____

17. (a) _____ (b) Date thereof _____ (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) _____ (b) _____ (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State _____ (b) County _____

(c) City or town _____ (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 *Feb* year *1945* hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____ to _____, 19 _____

that I last saw him _____, 19 _____ and that death occurred on the date and hour stated above.

Immediate cause of death _____ Duration _____

Due to *Primary Factor Uremia*
*Contributory Factor*Due to *Secondary to Chronic*
Suppurative cystitis

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

Major findings: Of operations _____

Of autopsy _____ *1330*

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? _____

While at work? _____ (Specify type of place) (e) Means of injury _____

23. Signature _____ (M. D. or other)

Address _____ Date signed _____

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

MOTHER FATHER

SUPPLEMENTARY

40508