

MISSOURI DIVISION OF HEALTH  
STANDARD CERTIFICATE OF DEATHState File No. **32241**National Office of Vital Statistics  
1100 Morgan Building  
St. Louis, Mo. 63101Registration District No. **53**Primary Registration District No. **3010**

Registrar's No. \_\_\_\_\_

## 1. PLACE OF DEATH:

(a) County **Cape Girardeau**  
 (b) City or town **Cape Girardeau Mo.**  
 (If outside city or town limits, write "RURAL" and name of township)  
 (c) Name of hospital or institution:  
**St. Francis Hospt. D**  
 (If not in hospital or institution, write street number or location)  
 (d) Length of stay: In hospital or institution **1 day**  
 (Specify whether years, months or days)

## 3. (a) PRINT FULL NAME

**Linda Kay Price**3. (b) If veteran, name war. **-**

3. (c) Social Security No. \_\_\_\_\_

4. Sex **F** / race **W**  
 5. Color or race **W**  
 6. (a) Single, widowed, married, divorced **X** / **11**  
 6. (b) Name of husband or wife **-**  
 6. (c) Age of husband or wife if alive **-** years  
 7. Birth date of deceased **July 14 1948**  
 (Month) (Day) (Year)

8. AGE: Years Months Days If less than one day  
**2 21** hr. - min.

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

10. Usual occupation **Charles W.**

11. Industry or business **-**

12. Name **Charles W. Price**

13. Birthplace **Sikeston, Mo. rt #1** (City, town, or county) (State or foreign country)

14. Maiden name **Maxine Warren**

15. Birthplace **Cook Minn** (City, town, or county) (State or foreign country)

16. (a) Informant **Charles W. Price**

(b) Address **Commerce Mo. Rt #1**

17. (a) **Burial** (b) Date thereof **Oct. 6/1948**  
 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Carpenter Cemetery**

18. (a) Signature of funeral director **John Albritton**

(b) Address **Sikeston, Mo.**

19. (a) **10-30-48** (b) **C. C. SUMMERS**  
 (Date received local registrar) (Registrar's signature)

## 2. USUAL RESIDENCE OF DECEASED:

(a) State **Mo.** (b) County **Scott**  
 (c) City or town **Commerce Mo. rt #1**  
 (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 **Oct** day **5th**  
 year **1948** hour **9** minute **30** a.m.

21. I hereby certify that I attended the deceased from **October 2nd**  
 19**48**, to **October 5th** 19**48**  
 that I last saw her alive on **October 5** 19**48**  
 and that death occurred on the date and hour stated above.

Immediate cause of death **Acute Enterocolitis (membranous)** **4.5 days**

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions **Premature Infant**  
 (Include pregnancy within 3 months of death)

Major findings: \_\_\_\_\_

Of operations: \_\_\_\_\_

Of autopsy: \_\_\_\_\_

## PHYSICIAN

Underline the cause of 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? \_\_\_\_\_ (Specify type of place)

23. Signature **M. P. Bryan** (M. D. or other) **D.O.**

Address **Benton, Mo.** Date signed **10-6-48**

RECEIVED

District Health Officer No. 4

District File Number 1048-1309

Date Filed 10-25-48

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.....

*Not embalmed*

Registered Apprentice No.....

working under my personal supervision.

Signed.....

*John Allerton*

Licensed Embalmer No. 2961

P. O. Address Substation on

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.

Registration District No. 53

Primary Registration District No. 3010

Registrar's No. 331

1. PLACE OF DEATH:

(a) County Cape Girardeau  
(b) City or town Cape Girardeau  
(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 Linda K. Prill

3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

4. Sex F 5. Color or race W 6. (a) Single, widowed, married, divorced S

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

7. Birth date of deceased \_\_\_\_\_ (Month) (Day) (Year)

8. AGE: Years \_\_\_\_\_ Months \_\_\_\_\_ Days \_\_\_\_\_ If less than one day hr. \_\_\_\_\_ min.

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

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 \_\_\_\_\_ (Month) (Day) (Year).  
(Burial, cremation, or removal)

(c) Place: burial or cremation \_\_\_\_\_

18. (a) Signature of funeral director \_\_\_\_\_

(b) Address \_\_\_\_\_

19. (a) 10-30-78 (b) G. G. Summers  
(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 \_\_\_\_\_ Year 1978 hour \_\_\_\_\_ minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_, 19\_\_\_\_; to \_\_\_\_\_, 19\_\_\_\_; and that death occurred on the date and hour stated above.  
Immediate cause of death \_\_\_\_\_

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions \_\_\_\_\_ (Include pregnancy within 3 months of death)

Major findings: Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

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 \_\_\_\_\_

21. Signature \_\_\_\_\_ (M. D. or other)

Date signed \_\_\_\_\_

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

MOTHER FATHER

SUPPLEMENTARY

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

S-32241

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