

FILED DEC 1 1948

Registration District No. 128

Primary Registration District No. 5465

Registrar's No. 1011

## 1. PLACE OF DEATH:

(a) County Greene  
 (b) City or town Rural N. Cambell Twsp.  
 (If outside city or town limits, write "RURAL" and name of township)  
 (c) Name of hospital or institution:  
Springfield R.F.D. # 4  
 (If not in hospital or institution, write street number or location)  
 (d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether  
 In this community 60 years years, months or days)

3. (a) PRINT FULL NAME Laura Sizourney Price

3. (b) If veteran, name war none  
 3. (c) Social Security No. none

4. Sex Female 5. Color or race White  
 6. (a) Single, widowed, married, divorced, widowed  
 6. (b) Name of husband or wife John J. Price  
 6. (c) Age of husband or wife if alive deceased years  
 7. Birth date of deceased March 27, 1868  
 (Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	80	7	22	hr. min.

9. Birthplace Warrensburg, Missouri  
(City, town, or county) (State or foreign country)10. Usual occupation none11. Industry or business none

MOTHER FATHER { 12. Name Joshua D. Pollock  
 13. Birthplace unknown England  
 (City, town, or county) (State or foreign country)  
 14. Maiden name Jennie Barton  
 15. Birthplace unknown Pennsylvania  
 (City, town, or county) (State or foreign country)

16. (a) Informant John Price(b) Address Charles City, Iowa17. (a) Burial (b) Date thereof 11/22/1948  
(Burial, cremation, or removal) (Month) (Day) (Year)(c) Place: burial or cremation Republic, Missouri18. (a) Signature of funeral director Fred C. Thieme(b) Address Springfield, Missouri19. (a) 11-24-48 (b) W. S. Handley M.D.  
(Date received local registrar) (Registrar's signature)

## 2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Greene  
 (c) City or town Rural - Springfield  
 (If outside city or town limits, write "RURAL")  
 (d) Street No. Springfield R.F.D. # 4  
 (If rural, give location)  
 (e) Citizen of foreign country? No (Yes or No)  
 If yes, name country \_\_\_\_\_

## MEDICAL CERTIFICATION

20. DATE OF DEATH: Month November day 19th  
year 1948 hour 8: minute 20 P. M.

21. I hereby certify that I attended the deceased from  
Oct 21, 1948, 19\_\_\_\_, to Nov. 19, 1948, 19\_\_\_\_;  
 that I last saw her alive on November 19, 1948, 19\_\_\_\_;  
 and that death occurred on the date and hour stated above.

Immediate cause of death Bronchopneumonia Duration  
(hypostatic) 4 days

Due to Fractured femur, necessitating  
absolute bed rest.

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

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

Major findings:

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

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

PHYSICIAN

Underline  
the cause to  
which death  
should be  
attributed.  
ADDITIONAL  
SUPPLEMENTARY  
INFORMATION

22. If death was due to external causes, fill in the following: INFORMATION

(a) Accident, suicide, or homicide (specify) \_\_\_\_\_ REQUESTED

(b) Date of occurrence \_\_\_\_\_ 39

(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 James C. Brown M.D. Date signed 11-22-48  
Address Greene Co. Health Dept.

**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..... *Ralph H. Thiem*.....

Licensed Embalmer No. 3681.....

P. O. Address Springfield, Missouri.....

**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.

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. See  
Registrar's No. 1011

Registration District No. 128 Primary Registration District No. 5465

1. PLACE OF DEATH:

(a) County Greene  
(b) City or town Rural  
(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

Laura S. Prine

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 wid

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

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

8. AGE: Years 80 Months 7 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 \_\_\_\_\_ (Month) (Day) (Year)  
(Burial, cremation, or removal)

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

13. (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 \_\_\_\_\_ year 1949 hour \_\_\_\_\_ minute \_\_\_\_\_ M.

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

Duration

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

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

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? \_\_\_\_\_

While at work? \_\_\_\_\_ (Specify type of place) (c) Means of injury \_\_\_\_\_

23. Signature James G. Brown (M. D. or other) MD

Address Greene Co. Health Dept. Date signed 12-8-48

SUPPLEMENTARY

RECORDING DEPARTMENT - MAKE A PERMANENT RECORD

S-34236

(52)-36236

GREENE COUNTY HEALTH DEPARTMENT  
CO-OPERATING WITH  
DIVISION OF HEALTH OF MISSOURI

OFFICE OF  
MEDICAL OFFICER  
IN CHARGE

SPRINGFIELD, MO.  
December 16, 1948

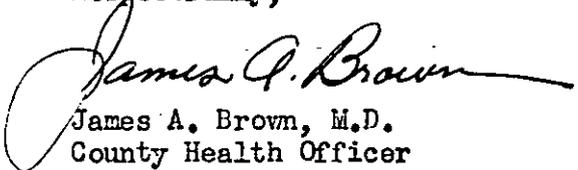
Mr. Elwood Musselman  
Vital Statistics Registrar  
Bureau of Vital Statistics  
Division of Health  
Jefferson City, Missouri

Dear Mr. Musselman:

In reference to the enclosed supplementary death certificate and attached memo; I would like it to be noted that item #22 starts out, "If death was due to external causes". This lady did not die because of a broken leg, she died of bronchopneumonia.

To comply with attached memo I will give you the following information. This lady was a sanity case and was a patient at Greene County Hospital. During the night of October 24, 1948, she fell out of bed and fractured her left thigh bone. Of necessity, she was confined to absolute bed rest during which she developed bronchopneumonia and expired November 19, 1948.

Respectfully,

  
James A. Brown, M.D.  
County Health Officer

JAB:wg

