

FILED MAR 10 1950 STANDARD CERTIFICATE OF DEATH

66224

State File No.

BIRTH NO. _____ REG. DIST. NO. **318** PRIMARY REG. DIST. **1003** Registrar's No. **1811**

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE MO b. COUNTY 2229	
b. CITY (If outside corporate limits, write RURAL and give township) St. Louis		c. CITY (If outside corporate limits, write RURAL and give township) St. Louis	
d. FULL NAME OF HOSPITAL OR INSTITUTION Homer G Phillips Hospital		d. STREET ADDRESS (If rural, give location) 2726 2632 Papan St	
3. NAME OF DECEASED (Type or Print) a. (First) David b. (Middle) _____ c. (Last) Price		4. DATE OF DEATH (Month) (Day) (Year) Feb. 21 1950	
5. SEX Male	6. COLOR OR RACE Col	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widow	8. DATE OF BIRTH Sept 24-1869
9. AGE (In years last birthday) 80		IF UNDER 1 YEAR Months	IF UNDER 1 YEAR Days
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Nil		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Clombus Ky		12. CITIZEN OF WHAT COUNTRY?	

13a. FATHER'S NAME Nelson Price	13b. MOTHER'S MAIDEN NAME Lizzie	14. NAME OF HUSBAND OR WIFE Dead
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S SIGNATURE OR NAME Josephine Vincent	ADDRESS 2632 Papan
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18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) <i>*This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.</i>	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Generalized Arteriosclerosis		Undet.
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. Chronic Pyelonephritis		"
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		"	

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>
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21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) 332X
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?
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22. I hereby certify that I attended the deceased from **2-6**, 19 **50**, to **2-21**, 19 **50**, that I last saw the deceased alive on **2-21**, 19 **50** and that death occurred at **10:38 p.m.**, from the causes and on the date stated above.

23a. SIGNATURE <i>Miss O'Brien</i> M. D.	(Degree or title)	23b. ADDRESS 2601 N Whittier St	23c. DATE SIGNED 2-23-50
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24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE Feb. 27	24c. NAME OF CEMETERY OR CREMATORY Washington Park	24d. LOCATION (City, town, or county) (State) St. Louis County
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DATE REC'D BY LOCAL REG. FEB 24 1950	REGISTRAR'S SIGNATURE <i>J. B. Susater</i>	25. FUNERAL DIRECTOR'S SIGNATURE <i>J. J. Hahn</i>	ADDRESS 2769 Chouteau
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

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 _____

working under my personal supervision.

Student Embalmer No.

Signed _____

Signed.....

Student Embalmer

Licensed Embalmer No. *269 P*

P. O. Address *2764 Charlotte*

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.