

FILED AUG 7 1950

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 24380

BIRTH NO. _____ REG. DIST. NO. 294 PRIMARY REG. DIST. NO. 3056 Registrar's No. 181

1. PLACE OF DEATH a. COUNTY <i>Randolph</i>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <i>Missouri</i> b. COUNTY <i>Chariton</i>	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <i>Moberly</i>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <i>Kylesville township 0210</i>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <i>Woodlawn Hosp.</i>		d. STREET ADDRESS (If rural, give location) <i>Kylesville Mo RFD# 1</i>	

3. NAME OF DECEASED (Type or Print) a. (First) <i>ARTHUR</i>	b. (Middle) <i>—</i>	c. (Last) <i>PRICE</i>	4. DATE OF DEATH (Month) (Day) (Year) <i>July 21 1950</i>
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5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <i>Never married</i>	8. DATE OF BIRTH <i>Sept. 22, 1884</i>	9. AGE (In years last birthday) <i>63</i>	10. MONTHS <i>9</i>	11. BIRTHPLACE (State or foreign country) <i>Unknown</i>	12. CITIZEN OF WHAT COUNTRY? <i>USA</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Farmer</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Farmer</i>					

13a. FATHER'S NAME <i>James B. Price</i>	13b. MOTHER'S MAIDEN NAME <i>Mattie Cawthorne</i>	14. NAME OF HUSBAND OR WIFE <i>None</i>
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>no</i>	16. SOCIAL SECURITY NO. <i>no</i>	17. INFORMANT'S SIGNATURE OR NAME <i>Edward Dervese Brunwald Mo.</i>	ADDRESS
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18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). *This does not mean the mode of dying, such as heart failure, asphyxia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <i>Strangulated Hernia</i>		INTERVAL BETWEEN ONSET AND DEATH <i>5 days</i>
	ANTECEDENT CAUSES Morbid conditions, if any, giving DUE TO (b) rise to the above cause (a) stating the underlying cause last. DUE TO (c) <i>Malnutrition</i>		
	II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <i>Malnutrition</i>		<i>5605</i>

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION <i>Strangulated Inguinal Hernia</i>	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g. home or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from *July 17, 1950*, to *July 21, 1950*, that I last saw the deceased alive on *July 20, 1950*, and that death occurred at *12:20 A.M.*, from the causes and on the date stated above.

23a. SIGNATURE <i>James E. Campbell M.D.</i>	(Degree or title)	23b. ADDRESS <i>Woodlawn Hospital</i>	23c. DATE SIGNED <i>7/21/50</i>
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24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE <i>July 23 1950</i>	24c. NAME OF CEMETERY OR CREMATORY <i>Rosehill</i>	24d. LOCATION (City, town, or county) (State) <i>Brookfield Mo.</i>
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DATE REC'D BY LOCAL REG. <i>7-23-50</i>	REGISTRAR'S SIGNATURE <i>Earl Helian Lowe</i>	FUNERAL DIRECTOR'S SIGNATURE <i>James M. Laughlin</i>	ADDRESS
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WRITE PLAINLY—USING UNFADEING BLACK INK—MAKE A PERMANENT RECORD

RECEIVED JUL 31 1950
District Health Officer No. 10
District File Number 8-50-1252
Date Filed AUG 4 1950

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 _____

Student Embalmer No. _____

working under my personal supervision.

Student _____
Student Embalmer

Signed Francis L. Scholberg

Licensed Embalmer No. 4513

P. O. Address Marceline 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.