

FILED JAN 3 1951

 THE DIVISION OF HEALTH OF MISSOURI
 STANDARD CERTIFICATE OF DEATH

41735

State File No.

BIRTH NO. _____		REG. DIST. NO. <u>274</u>		PRIMARY REG. DIST. NO. <u>4407</u>		Registrar's No. <u>403</u>	
1. PLACE OF DEATH				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
a. COUNTY <u>Pettis</u>		b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>LaMonte</u>		a. STATE <u>Missouri</u>		b. COUNTY <u>Pettis</u>	
c. LENGTH OF STAY (in this place)		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>LaMonte</u>		d. STREET ADDRESS (If rural, give location)			
d. FULL NAME OF HOSPITAL OR INSTITUTION				d. STREET ADDRESS (If rural, give location)			
3. NAME OF DECEASED			4. DATE OF DEATH			5. SEX	
a. (First)	b. (Middle)	c. (Last)	(Month)	(Day)	(Year)	Female	6. COLOR OR RACE
<u>Ella</u>	<u>Price</u>	<u>Guthrie</u>	<u>12</u>	<u>22</u>	<u>1950</u>		<u>White</u>
(Type or Print)							
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)		8. DATE OF BIRTH		9. AGE (In years last birthday)		IF UNDER 1 YEAR	IF UNDER 24 HRS.
<u>Widowed</u>		<u>June 25 1885</u>		<u>85</u>		Months	Days
						Hours	Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<u>House Wife</u>				<u>Ohio</u>		<u>U.S.A.</u>	
13a. FATHER'S NAME		13b. MOTHER'S MAIDEN NAME		14. NAME OF HUSBAND OR WIFE			
<u>Hugh M. Price</u>		<u>Ann E. Tidball</u>		<u>R. E. Guthrie</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT'S SIGNATURE OR NAME			
<u>No</u>		<u>None</u>		<u>E. D. Guthrie LaMonte Mo.</u>			
18. CAUSE OF DEATH		MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH	
Enter only one cause per line for (a), (b), and (c)		I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a)				<u>15 22 2</u>	
*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.		ANTECEDENT CAUSES					
		Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last.					
		DUE TO (b)					
		DUE TO (c)					
		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?	
<input checked="" type="checkbox"/>						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
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)			
<input checked="" type="checkbox"/>		<u>LaMonte</u>		<u>Pettis</u> <u>Mo</u>			
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?			
<input checked="" type="checkbox"/>		<input type="checkbox"/>		<input checked="" type="checkbox"/>			
22. I hereby certify that I attended the deceased from <u>Dec 1, 1950</u> , to <u>Dec 22, 1950</u> , that I last saw the deceased alive on <u>Dec 22, 1950</u> and that death occurred at <u>10:47 a.m.</u> , from the causes and on the date stated above.							
23a. SIGNATURE (Degree or title)		23b. ADDRESS		23c. DATE SIGNED			
<u>H. W. Cravens</u>		<u>Knox, Noster, Mo.</u>		<u>Dec 22-3</u>			
24a. BURIAL, CREMATION, REMOVAL (Specify)		24b. DATE	24c. NAME OF CEMETERY OR CREMATORY		24d. LOCATION (City, town, or county) (State)		
<u>Burial</u>		<u>12-23-50</u>	<u>LaMonte Cemetery</u>		<u>LaMonte Mo.</u>		
DATE REC'D BY LOCAL REG.		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
<u>12-26-1950</u>		<u>E. D. Campbell</u>		<u>Robert Hall</u>		<u>LaMonte Mo</u>	
(Licensed Embalmer's Statement on Reverse)							

WRITE PLAINLY—USING UNFAADING BLACK INK—MAKE A PERMANENT RECORD

RECEIVED 1-251
DISTRICT HEALTH OFFICE No. 3
District File Number _____
Date Filed 1-251

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 Paul M. Moore

Licensed Embalmer No. 3923

P. O. Address La Monte, 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.