

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **4455**

BIRTH NO. **FILED FEB 25 1954** REG. DIST. NO. **114** PRIMARY REG. DIST. NO. **4186** Registrar's No. **8**

1. PLACE OF DEATH a. COUNTY FRANKLIN		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE MO b. COUNTY FRANKLIN	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN SULLIVAN MERAMEC		c. LENGTH OF STAY (In this place) 87yr	c. CITY OR TOWN SULLIVAN MO.
d. FULL NAME OF HOSPITAL OR INSTITUTION LINDSEY NURSING HOME		d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
		e. STREET ADDRESS (If rural, give location) 03610	

3. NAME OF DECEASED (Type or Print) a. (First) STERLING	b. (Middle) PRICE	c. (Last) SCOTT	4. DATE OF DEATH (Month) (Day) (Year) 2 16 1954
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) WIDOWED	8. DATE OF BIRTH 12-18-1866
9. AGE (In years last birthday) 87		10. KIND OF BUSINESS OR INDUSTRY CARPENTER	11. BIRTHPLACE (City and State or Foreign Country) MO.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED		12. CITIZEN OF WHAT COUNTRY? U.S.A	

13a. FATHER'S NAME PRICE SCOTT	13b. MOTHER'S MAIDEN NAME UNKNOWN	14. NAME OF HUSBAND OR WIFE MARTHA OLIVE STRAIN
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No	16. SOCIAL SECURITY NO.	17. INFORMANT'S SIGNATURE OR NAME Mrs Edith Carpenter ADDRESS Sullivan Mo

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, asthma, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Myocarditis (b) senility (c) Several years		INTERVAL BETWEEN ONSET AND DEATH
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. none			

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION 4222	20. AUTOPSY? 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)
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 **1940**, to **Feb 15, 1954**, that I last saw the deceased alive on **Feb 15, 1954**, and that death occurred at **5 2** m., from the causes and on the date stated above.

23a. SIGNATURE R.P. Royce M.D. (Degree or title)	23b. ADDRESS 316 Elm St. Sullivan, Mo.	23c. DATE SIGNED 2/15/54
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24a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	24b. DATE 2-18-1954	24c. NAME OF CEMETERY OR CREMATORY BOURBON CEMETERY	24d. LOCATION (City, town, or county) (State) BOURBON MO.
DATE REC'D BY LOCAL REG. 2/17/54	REGISTRAR'S SIGNATURE Thomas A. Dempsey 496-7	25. FUNERAL DIRECTOR'S SIGNATURE Chas. Shaffer ADDRESS Sullivan Mo	

(Licensed Embalmer's Statement on Reverse Side)

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

2361

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 me....., Student Embalmer No..... working under my personal supervision..

Student.....
Signature of Student Embalmer

Signed Paul F. Krollenb

Licensed Embalmer No. 263

P. O. Address Sullivan

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.