

FILED AUG 2 - 1955

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. 24231  
Registrar's No. 5445

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Illinois		b. COUNTY St. Clair	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis		c. LENGTH OF STAY (In this place) 6 days		c. CITY OR TOWN E. St. Louis	
d. FULL NAME OF HOSPITAL OR INSTITUTION Peoples Hospitla		STREET ADDRESS (If rural, give location) 1629 Bond Avenue		d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input type="checkbox"/>	

3. NAME OF DECEASED (Type or Print) Matthew Price			4. DATE OF DEATH (Month) (Day) (Year) 6-21-55		
a. (First)		b. (Middle)		c. (Last)	

5. SEX Male		6. COLOR OR RACE Negro		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widow		8. DATE OF BIRTH Jan. 12, 1889		9. AGE (In years last birthday) 66		IF UNDER 1 YEAR Months 5		IF UNDER 24 HRS. Days		IF UNDER 1000 HRS. Hours		Min.	
-------------	--	------------------------	--	--	--	--------------------------------	--	------------------------------------	--	--------------------------	--	-----------------------	--	--------------------------	--	------	--

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY Unemployed		11. BIRTHPLACE (City and State or Foreign Country) Rolling Fork, Mississippi				12. CITIZEN OF WHAT COUNTRY? USA			
--	--	--	--	--	--	--	--	----------------------------------	--	--	--

13a. FATHER'S NAME Tom Price			13b. MOTHER'S MAIDEN NAME Ann ?			14. NAME OF HUSBAND OR WIFE					
------------------------------	--	--	---------------------------------	--	--	-----------------------------	--	--	--	--	--

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. none		17. INFORMANT'S SIGNATURE OR NAME ADDRESS Willie Wells 1629 Bond Ave.					
---	--	------------------------------	--	--	--	--	--	--	--

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, asthenia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Chronic Glomerular Nephritis ANTECEDENT CAUSES Prostatic Hypertrophy Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) II. OTHER SIGNIFICANT CONDITIONS Cerebral Thrombosis Conditions contributing to the death but not related to the disease or condition causing death. DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH 6 mos (Heart) 10 mos Heart 2 wks	
---	--	---	--	--	--	--	--	--	--

19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				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) (Min)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? 610X	

22. I hereby certify that I attended the deceased from 6-8-55 to 6-20-55, that I last saw the deceased alive on 6-20-55 and that death occurred at 5:55 a.m., from the causes and on the date stated above.

23a. SIGNATURE W.A. Fingal M.D.		23b. ADDRESS 1652 Central E St Louis, Ill.		23c. DATE SIGNED 6-21-55	
---------------------------------	--	--	--	--------------------------	--

24a. BURIAL, CREMATION, REMOVAL (Specify) Removal		24b. DATE 6-23-55		24c. NAME OF CEMETERY OR CREMATORY Booker Washington		24d. LOCATION (City, town, or county) (State) East St. Louis, Ill.,	
---	--	-------------------	--	--	--	---	--

DATE REC'D BY LOCAL REG. JUN 23 1955		REGISTRAR'S SIGNATURE J. Carl Smith mps		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS C. T. Nash 111 N. 13	
--------------------------------------	--	---	--	---	--

(Licensed Embalmer's Statement on Reverse Side)

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

Student.....  
Signature of Student Embalmer

Signed..... *C. J. Nash*

Licensed Embalmer No. *24*

P. O. Address *3847*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (F 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.