

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

28601  
STATE FILE NUMBER

FILED AUG 20 1957

Registration District No. 170 Primary Registration District No. 3033 Registrar's No. 139

|   |                                  |   |  |  |   |  |  |
|---|----------------------------------|---|--|--|---|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Laclede</u>   |                                  |   |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <u>Missouri</u> b. COUNTY <u>Laclede</u> |   |  |  |
| b. CITY (If outside corporate limits, give TOWNSHIP only)<br>OR TOWN <u>Lebanon</u>   |                                  | Inside Limits<br>Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>      |  | c. CITY OR TOWN <u>Lebanon</u>   |   | Inside Limits<br>Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> |  |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Wallace Hosp.</u>  |                                  |   | Length of stay in 1b <u>2 days</u>   | d. STREET ADDRESS (If outside, give location) <u>814 N. Adams</u>  |   |  | Reside on Farm<br>Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>                  |
| 3. NAME OF DECEASED (Type or print)<br>First <u>Fred</u> Middle <u>Benton</u> Last <u>Price</u>   |                                  |   |  | 4. DATE OF DEATH<br>Month <u>Aug.</u> Day <u>13</u> Year <u>1957</u>   |   |  |  |
| 5. SEX <u>male</u>  | 6. COLOR OR RACE <u>white</u>    | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>     | 8. DATE OF BIRTH <u>Dec 5, 1900</u>  | 9. AGE (In years last birthday) <u>56</u>  | IF UNDER 1 YEAR<br>Months <u>1</u> Days <u>1</u> Hours <u>1</u> Min. <u>1</u> | IF UNDER 24 HRS.<br>Hours <u>1</u> Min. <u>1</u>                                     | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>none</u> |
| 100. KIND OF BUSINESS OR INDUSTRY <u>none</u>   |                                  | 11. BIRTHPLACE (City and state or country) <u>Caney Kansas</u>                            |  | 12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>   |   |  |  |
| 13. FATHER'S NAME <u>Joseph S. Price</u>  |                                  |   |  | 14. MOTHER'S MAIDEN NAME <u>Sarah M. Shields</u>   |   |  |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (yes, no, or unknown) <u>no</u>  |                                  | 16. SOCIAL SECURITY NO. <u>none</u>   |  | 17. INFORMANT <u>Mrs. Myrtle Myers Lebanon, Mo.</u><br>Address   |   |  |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Chronic myocarditis</u><br>DUE TO (b) <u>Thyrotropic heart disease</u><br>DUE TO (c) <u>Toxic goiter</u><br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>2520</u> |                                  |   |  |  |   | INTERVAL BETWEEN ONSET AND DEATH<br><u>2 yrs.</u><br><u>8 yrs.</u>                   |  |
| 20a. ACCIDENT <input type="checkbox"/>  | SUICIDE <input type="checkbox"/> | HOMICIDE <input type="checkbox"/>   | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) |  |   |  |  |
| 20c. TIME OF INJURY<br>Hour <u>5:30</u> Month <u>Aug.</u> Day <u>13</u> Year <u>1957</u><br>a. m. <u>A.</u> p. m.   |                                  |   |  |  |   |  |  |
| 20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |                                  | 20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) |  | 20f. CITY, TOWN, OR LOCATION   |   | COUNTY STATE   |  |
| 21. I attended the deceased from <u>1949</u> to <u>8-13-57</u> and last saw <u>him</u> alive on <u>8-12-57</u><br>Death occurred at <u>5:30 A.</u> m on the date stated above; and to the best of my knowledge, from the causes stated.   |                                  |   |  |  |   |  |  |
| 22a. SIGNATURE (Degree or title) <u>B. B. Hurst, M.D.</u>   |                                  |   |  | 22b. ADDRESS <u>Lebanon, Mo.</u>   |   | 22c. DATE SIGNED <u>8-13-57</u>  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>  |                                  | 23b. DATE <u>8/14/57</u>  | 23c. NAME OF CEMETERY OR CREMATORY <u>Sunny Side Cemetery</u>                                |  | 23d. LOCATION (City, town, or county) (State) <u>Caney Kansas</u>             |  |  |
| 24. FUNERAL DIRECTOR <u>Holman Lebanon, Mo.</u> ADDRESS   |                                  |   |  | 25. DATE RECD. BY LOCAL REG. <u>8-14-1957</u>  |   | 26. REGISTRAR'S SIGNATURE <u>Hella L. Hlay</u>                                       |  |

diseases in Part I must be causally related. Coroner cannot certify to a death due to natural causes.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

Received <sup>19</sup> 8-18-57  
Laclede County Health Unit  
File No. 139  
Date Filed 8-18-57  
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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 *Dorsey M. How*

Licensed Embalmer No. 42

P. O. Address *Lebanon*

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