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FILED AUG 26 1957

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

29905
STATE FILE NUMBER
Registrar's No. 7193

Registration District No. 318 Primary Registration District No. 1003

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis		c. CITY OR TOWN St. Louis	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Bethesda General Hospital		d. STREET ADDRESS (If outside, give location) 1800 Park Avenue	
3. NAME OF DECEASED (Type or print) First Middle Last Carlind - Price		4. DATE OF DEATH Month Day Year August 1 1957	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 21, 1957
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		11. BIRTHPLACE (City and state or country) St. Louis, Missouri	
13a. FATHER'S NAME Jasper Price		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		17. INFORMANT Address Mrs. Elizabeth Price, 1800 Park Avenue	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonia left lung			INTERVAL BETWEEN ONSET AND DEATH 7-25-57
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) Pleural Effusion left			7-23-57
DUE TO (c) H93.X-			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Otitis media left, Cellulitis left side neck's chest.			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT SUICIDE HOMICIDE <input type="checkbox"/> <input type="checkbox"/> <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 Hour Month, Day, Year a.m. p.m.			
20d. INJURY OCCURRED WHILE AT <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 June 21, 1957 to Aug 1, 1957 and last saw ^{her} him alive on Aug 1, 1957 Death occurred at 9:30 A.M. on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) Leroy E. Ellison MD		22b. ADDRESS 3610 So Broadway St Louis Mo	
		22c. DATE SIGNED 8-1-57	
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal		23b. DATE 8-4-1957	
23c. NAME OF CEMETERY OR CREMATORY Methodist Cemetery		23d. LOCATION (City, town, or county) (State) Calendonia, Missouri	
24. FUNERAL DIRECTOR ADDRESS McLAUGHLIN'S, 2301 Lafayette		25. DATE RECD. BY LOCAL REG. AUG 2 57	
		26. REGISTRAR'S SIGNATURE J. Call Smith MD <i>mgs</i>	

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

All diseases in Part I must be causally related.

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 *James R. Chapman*

Licensed Embalmer No. *455*

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