

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

59-014062

STATE FILE NUMBER

FILED MAY 12 1959

Registration District No. 187 Primary Registration District No. 3040 Registrar's No. 118

S. 300  
1-57

New Director

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

1. PLACE OF DEATH a. COUNTY <u>Livingston</u>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Livingston</u>		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Chillicothe</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>Chillicothe</u> <u>05920</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>City hospital</u>		Length of stay in 1b <u>2 days</u>	d. STREET ADDRESS (If outside, give location) <u>Rt. #1, Harvester Rd.</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last <u>JOHN PRICE</u>			4. DATE OF DEATH Month Day Year <u>May 2, 1959</u>		
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 1, 1959</u>		9. AGE (In years last birthday) IF UNDER 1 YEAR: Months <u>2</u> Days <u>2</u> IF UNDER 24 HRS.: Hours <u>2</u> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>	11. BIRTHPLACE (City and state or country) <u>Chillicothe, Mo.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
13a. FATHER'S NAME <u>Michael Price</u>		13b. MOTHER'S MAIDEN NAME <u>Sarah Jane McDonald</u>		14. NAME OF HUSBAND OR WIFE <u>XX</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>None</u>	17. INFORMANT Address <u>Michael Price, Chillicothe, Mo.</u>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Atelectasis Embolus Rt lung</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) <u>+ pulmonary edema</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>7620</u>					INTERVAL BETWEEN ONSET AND DEATH <u>12 hrs</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 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 <u>1 May</u> to <u>2 May</u> and last saw <sup>her</sup> <sub>him</sub> alive on <u>2 May</u> Death occurred at <u>10:30</u> P. m on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE (Degree or title) <u>V D Vandivina M. D.</u>			22b. ADDRESS <u>Chillicothe Mo</u>		22c. DATE SIGNED <u>4 May 59</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>May 5, 1959</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Catholic cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Chillicothe, Mo.</u>	
24. FUNERAL DIRECTOR ADDRESS <u>Donald Gordon, Chillicothe, Mo.</u>		25. DATE RECD. BY LOCAL REG. <u>5-4-59</u>	26. REGISTRAR'S SIGNATURE <u>Frances B Neill</u>		

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 *Russell Godwin* .....

Licensed Embalmer No. *4191* .....

P. O. Address *Phillips* .....

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.