

FILED VS JAN 25 1960

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-046870
STATE FILE NUMBER

Registration District No. 71 Primary Registration District No. 3012 Registrar's No. 119

V. S. 300
Rev. 1-57

securing the medical certification in the specific manner required by 193.140 MoRS 1949.
 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
 MEDICAL CERTIFICATION

1. PLACE OF DEATH a. COUNTY Clay			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Lafayette		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Excelsior Springs		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN Lexington		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Veterans Administration Hospital		Length of stay in lb 6 mos 9 days	d. STREET ADDRESS (If outside, give location) 1314 Lafayette		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First THOMAS Middle NMI Last PRICE			4. DATE OF DEATH Month December Day 28 Year 1959		
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 3. WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH Dec. 20, 1894	9. AGE (In years last birthday) 65	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Common	11. BIRTHPLACE (City and state or country) Lexington, Missouri		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13a. FATHER'S NAME Thomas A. Price		13b. MOTHER'S MAIDEN NAME Annia V. Chambers		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) Yes WW I		16. SOCIAL SECURITY NO. None	17. INFORMANT Address VA Hospital records		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Rupture of abdominal aorta due to arteriosclerosis with retroperitoneal hemorrhage.					INTERVAL BETWEEN ONSET AND DEATH 100 min.
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.					DUE TO (b) Dissecting aneurysm of abdominal aorta. DUE TO (c) - - -
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
(1) Emphysema (2) Tuberculosis, pulmonary, moderately advanced, inactive					
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 WORK <input type="checkbox"/> 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. VA attended the deceased from June 19, 1959 to Dec. 28, 1959 Death occurred at 3:50 p. m. on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE F. J. MANTELL, M.D., Pathologist			22b. ADDRESS VACC, Ex. Spgs Div Excelsior Springs, Mo.		22c. DATE SIGNED 12-29-59
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE Dec. 31-1959	23c. NAME OF CEMETERY OR CREMATORY Machpelah Cemetery		23d. LOCATION (City, town, or county) (State) Lexington Mo.	
24. FUNERAL DIRECTOR WALKER FUNERAL HOME, MISSOURI		ADDRESS LEXINGTON	25. DATE RECD. BY LOCAL REG. 1/10/60	26. REGISTRAR'S SIGNATURE Caroline Hutchings	

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 *Ralph Van Landingham*
Licensed Embalmer No. *4009*
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.