

**MURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH**

**60-012235**

**FILED VS. MAR 30 1960 308**

STATE FILE NUMBER

Registration District No. \_\_\_\_\_ Primary Registration District No. 4454 Registrar's No. 1

UNRECORDED

<b>1. PLACE OF DEATH</b>		<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission)	
a. COUNTY <u>St. Charles</u>	a. STATE <u>Mo</u>	b. COUNTY <u>St. Charles</u>	b. COUNTY <u>St. Charles</u>
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Augusta</u>	Length of stay in 1b <u>10 mo.</u>	c. CITY OR TOWN <u>Augusta</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	Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (if outside, give location)	Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

<b>3. NAME OF DECEASED</b> (Type or print) First <u>Charles</u> Middle <u>Leslie</u> Last <u>Price</u>			<b>4. DATE OF DEATH</b> Month <u>March</u> Day <u>23</u> Year <u>1960</u>		
<b>5. SEX</b> <u>Male</u>	<b>6. COLOR OR RACE</b> <u>White</u>	<b>7. Married</b> <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <u>3-6-1901</u>	<b>9. AGE</b> (last birthday) <u>59</u>	<b>IF UNDER 1 YEAR</b> Months _____ Days _____
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>General Contractor</u>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>Construction</u>	<b>11. BIRTHPLACE</b> (City and state or country) <u>Unknown</u>	<b>12. CITIZEN OF WHAT COUNTRY</b> <u>U.S.A.</u>	

<b>13a. FATHER'S NAME</b> <u>Unknown</u>	<b>13b. MOTHER'S MAIDEN NAME</b> <u>Unknown</u>	<b>14. NAME OF HUSBAND OR WIFE</b> <u>Mary Louise Lancaster</u>
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service) <u>None</u>	<b>16. SOCIAL SECURITY NO.</b> <u>99-01-4859</u>	<b>17. INFORMANT</b> <u>Mary Theresa Sollmann</u> Address <u>Augusta, Mo.</u>

<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:		<b>INTERVAL BETWEEN ONSET AND DEATH</b>
IMMEDIATE CAUSE (a) <u>metastatic carcinoma liver, stomach</u>	DUE TO (b) <u>Carcinoma of the colon</u>	<u>2-2-60</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (c)	<u>Apr. 1959</u>

<b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH</b> but not related to the terminal disease condition given in PART I (a)	<b>PART III. If deceased was female was there a pregnancy in last 90 days.</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
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<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	<b>20a. ACCIDENT</b> <input type="checkbox"/> <b>SUICIDE</b> <input type="checkbox"/> <b>HOMICIDE</b> <input type="checkbox"/>	<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in PART I or PART II of item 18.)
<b>20c. TIME OF INJURY</b> Hour _____ a.m. _____ p.m. Month, Day, Year _____	<b>20d. INJURY OCCURRED WHILE AT WORK</b> <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	<b>20e. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.) _____
<b>20f. CITY, TOWN, OR LOCATION</b> _____		<b>COUNTY</b> _____ <b>STATE</b> _____

**21. I attended the deceased from** 2-15-60 to 3-23-60 and last saw him alive on 3-22-60  
 Death occurred at 3:30 A m on the date stated above, and to the best of my knowledge, from the causes stated.

<b>22a. SIGNATURE</b> <u>H.H. Schuudt MD</u> (Degree or title)	<b>22b. ADDRESS</b> <u>2nd &amp; Elm, Washington, Mo</u>	<b>22c. DATE SIGNED</b> <u>3-24-60</u>
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<b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b> <u>Burial</u>	<b>23b. DATE</b> <u>3-25-60</u>	<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>St. Trinity Lutheran Cemetery</u>	<b>23d. LOCATION</b> (City, town, or county) <u>St. Louis</u> (State) <u>Mo.</u>
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<b>24. FUNERAL DIRECTOR</b> <u>T. J. Pitman</u> ADDRESS <u>909 Pitman Ave. Wertzville, Mo.</u>	<b>25. DATE RECD. BY LOCAL REG.</b> <u>March 25, 1960</u>	<b>26. REGISTRAR'S SIGNATURE</b> <u>Mrs. Viola Shuesmeier</u>
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DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

MAY 12 1980

MAY 26 1980

JUN 21 1980

APR 1 1980

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 Carlton J. Pitman

Licensed Embalmer No. 4974

P. O. Address Wentzville

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.