

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

=62-025855

STATE FILE NUMBER

DO NOT WRITE
ON THIS STUB

AMENDED

Registration District No. 1 Primary Registration District No. 3000 Registrar's No. 222

VS 300
Rev. 4/59

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DATE AMENDED

INSTEAD OF

SHOULD READ

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY Adair		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo. b. COUNTY Adair	
b. CITY (If outside corporate limits, give TOWNSHIP only) Kirksville		c. CITY OR TOWN Kirksville	
Length of stay in 1b years		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) Nursing Home # 1		d. STREET ADDRESS (If outside, give location) 408 N. Franklin	
Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) JAMES CAMPBELL PRICE			4. DATE OF DEATH Month July Day 11 Year 1962
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 2/21/72
9. AGE (last birthday) 90		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HR Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY Farming	11. BIRTHPLACE (City and state or country) Hartford, Putnam, Mo.
12. CITIZEN OF WHAT COUNTRY U S			
13a. FATHER'S NAME William H. Price		13b. MOTHER'S MAIDEN NAME Mary Elizabeth Bruce	
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		16. SOCIAL SECURITY NO. No	
17. INFORMANT Ruth Fox, Kirksville, Mo.		Address	
18. CAUSE OF DEATH (Enter only one cause per line) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Overwhelming Toxemia Days			INTERVAL BETWEEN ONSET AND DEATH months
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) Obstructive Uropathy			months
DUE TO (c) Benign Prostatic Hypertrophy			months
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)			
PART III. If deceased was female was there a pregnancy in last 90 days. <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	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 a.m. p.m. Month, Day, Year			
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 7-12-62 to July 11, 1962 and last saw him alive on July 11, 1962 Death occurred at 8:05 A.M. on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Deceased or title) George H. Schauer, M.D.		22b. ADDRESS Kirksville	
22c. DATE SIGNED 7-12-62			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 7-13-62	23c. NAME OF CEMETERY OR CREMATORY Shibley Point	23d. LOCATION (City, town, or county) (State) Shibley Point, Adair, Mo.
24. FUNERAL DIRECTOR Foster Memorial Home, Kirksville, Mo.		25. DATE RECD. BY LOCAL REG. July 13, 1962	26. REGISTRAR'S SIGNATURE Doris W. Ratliff

USE BLACK INK
OR
TYPEWRITER RIBBON

MEDICAL CERTIFICATION - Schauer

PERMIT ISSUED July 13, 1962

GEORGE H. SCHUER, D.D.

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 Novak Lactis

Licensed Embalmer No. 4742

P. O. Address Subiaco, 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.