

**MISSOURI STATE BOARD OF HEALTH  
BUREAU OF VITAL STATISTICS  
CERTIFICATE OF DEATH**

Do not use this space.

13196

**1. PLACE OF DEATH**

County Jackson Registration District No. \_\_\_\_\_  
 Township Kaw Primary Registration District No. \_\_\_\_\_  
 City Kansas City (No. 5504 Harrison)

File No. \_\_\_\_\_  
 Registered No. 523  
 St. \_\_\_\_\_ Ward \_\_\_\_\_

**2. FULL NAME** James A Rice

(a) Residence No. 5504 Harrison St. 4<sup>th</sup> Ward \_\_\_\_\_  
 (Usual place of abode)  
 Length of residence in city or town where death occurred yrs. mos. 4 da. How long in U.S., if of foreign birth? yrs. mos. da.

**PERSONAL AND STATISTICAL PARTICULARS**

3. SEX <u>Male</u>	4. COLOR OR RACE <u>White</u>	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) <u>Married</u>
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF <u>Mrs. Agnes Rice</u>		
6. DATE OF BIRTH (MONTH, DAY AND YEAR) <u>June 19 1865</u>		
7. AGE	YEARS	MONTHS
	<u>62</u>	<u>9</u>
		13
8. OCCUPATION OF DECEASED (a) Trade, profession, or particular kind of work <u>Bookkeeper</u> (b) General nature of industry, business, or establishment in which employed (or employer) (c) Name of employer		

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) April 2 1928

17. I HEREBY CERTIFY, That I attended Deceased from Aug 12, 1927, to Apr 2, 1928  
 that I last saw him alive on Apr 1, 1928, and that death occurred, on the date stated above, at 4 A. M.

THE CAUSE OF DEATH\* WAS AS FOLLOWS:

Septicemic poison  
 (duration) 4 mos. 10 da.  
 CONTRIBUTORY (SECONDARY) Septicemia - Streptococcus  
 (duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ da.

**9. BIRTHPLACE (CITY OR TOWN)**

(STATE OR COUNTRY) Missouri

10. NAME OF FATHER Thomas Rice

11. BIRTHPLACE OF FATHER (CITY OR TOWN)  
 (STATE OR COUNTRY) Ireland

12. MAIDEN NAME OF MOTHER Letetia E Farrell

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)  
 (STATE OR COUNTRY) Ireland

14. INFORMANT Mrs. Agnes Rice  
 (Address) 5504 Harrison

15. FILED 4/3 28 M. M. Cooper  
 REGISTRAR

18. WHERE WAS DISEASE CONTRACTED  
 IF NOT AT PLACE OF DEATH \_\_\_\_\_

DID AN OPERATION PRECEDE DEATH? no. DATE OF \_\_\_\_\_

WHAT TEST CONFIRMED DIAGNOSIS?  
 (Signed) John O. Skinner, M. D.  
4-3 1928 (address) 356 Lathrop

\*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL Calvary Cemetery DATE OF BURIAL 4/4/28 19

20. UNDERTAKER Quirk & Tobin Co--20 West Linwood ADDRESS \_\_\_\_\_

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

RECORDING UNIT—THIS IS A PERMANENT RECORD

