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

Do not use this space.

35058

File No. .....
Registered No. 102

1. PLACE OF DEATH
County ~~[illegible]~~ Clay
Township Fishing River
City Excelsior Springs (No. ..... St. ..... Ward)

Registration District No. 198
Primary Registration District No. 3011

2. FULL NAME David Francis Rice

(a) Residence. No. ..... St., ... Ward. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred yrs. mos. 14 ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word): Married

5a. IF MARRIED, WIDOWED OR DIVORCED
HUSBAND OF (OR) WIFE OF Fannie Rice

6. DATE OF BIRTH (MONTH, DAY AND YEAR) March 10-1849

7. AGE: Years 79 | Months 6 | Days 25 | If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Farmer
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer .....

9. BIRTHPLACE (CITY OR TOWN) .....
(STATE OR COUNTRY) Ill.

PARENTS
10. NAME OF FATHER Alonzo Rice
11. BIRTHPLACE OF FATHER (CITY OR TOWN) .....
(STATE OR COUNTRY) New York
12. MAIDEN NAME OF MOTHER Esther Owen
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) .....
(STATE OR COUNTRY) New York

14. INFORMANT J K Rice
(Address) Lovilia Iowa

15. FILED 10/8, 1928 W.D. Crouch
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 10-8-1928

17. I HEREBY CERTIFY, That I attended deceased from 9-23-1928, to 10-8-1928, that I last saw h. alive on 10-7-1928, and that death occurred, on the date stated above, at 4.15 a.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS: Endocarditis (chronic) 2 yrs. 9 mo. (duration) 4 or more yrs. mos. ds.

CONTRIBUTORY (SECONDARY) Aortic aneurysm - Arteriosclerosis - Senility 5 yrs. (duration) yrs. mos. ds.

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

DID AN OPERATION PRECEDE DEATH? No. DATE OF .....

WAS THERE AN AUTOPSY? No

WHAT TEST CONFIRMED DIAGNOSIS? X-ray of chest

Dec. 11, 1928 (Signed) G. Mitchell, M. D.
(Address) Excelsior Springs Mo.

*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 Lovilia Iowa | DATE OF BURIAL Oct 9 1928

20. UNDERTAKER Herbert Fobes | ADDRESS Ex Springs

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.