

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

Do not use this space.

1046

FEB 21 1929

1. PLACE OF DEATH

County Crawford
Township 5
City Darlington (No. 1)

Registration District No. 310
Primary Registration District No. 14249
14126

File No. _____
Registered No. 5-9
St. _____ Ward _____

2. FULL NAME

Jennie L 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. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) single

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF _____

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Oct 14 - 1905

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, _____hra. or _____min.
	<u>23</u>	<u>2</u>	<u>22</u>	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work _____
(b) General nature of industry, business, or establishment in which employed (or employer) stenographer
(c) Name of employer _____

9. BIRTHPLACE (CITY OR TOWN) Entryville
(STATE OR COUNTRY) _____

10. NAME OF FATHER James Rice

11. BIRTHPLACE OF FATHER (CITY OR TOWN) _____
(STATE OR COUNTRY) Rinty Co Mo

12. MAIDEN NAME OF MOTHER Doloh Karikes

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Entryville
(STATE OR COUNTRY) Entry Co Mo

14. INFORMANT James Rice
(Address) Darlington Mo

15. FILED Feb 29 1929 Mary Inland
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 1-7-1929

17. I HEREBY CERTIFY That I attended deceased from Oct 1 - 1928, to 1-7-1929 that I last saw him alive on 12-26-1928, and that death occurred, on the date stated above, at 8 - 8 - P.M.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Appendicitis, pelvic peritonitis, pyemia
121B

129 (duration) yrs. 5 mos. ds.

31 CONTRIBUTOR (SECONDARY) (duration) yrs. mos. ds.

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

1. DID AN OPERATION PRECEDE DEATH? yes DATE OF Oct 2 - 28

WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS? clinical
(Signed) Frank H. Rose, M. D.

1-8-1929 (Address) Albany, 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 _____ DATE OF BURIAL _____

Rouse Cemetery Jan 9 1929

20. UNDERTAKER FR Shockey ADDRESS Albany Mo

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.

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2

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