

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

Do not use this space.

11098

1. PLACE OF DEATH

County Gallison Registration District No. 400
 Township Prairie Primary Registration District No. 55XP D
 City Little Blue mo (No. Little Blue mo)

File No. _____
 Registered No. 27
 St. _____ Ward _____

2. FULL NAME Mellie Rice

(a) Residence. No. 1009 W. 24th St. _____ Ward _____
 (Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 6 yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX F. 4. COLOR OR RACE negro 5. SINGLE, MARRIED, WIDOWED OR DIVORCED married

5A. ~~MARRIED, WIDOWED OR DIVORCED~~
 HUSBAND or (OR) WIFE OF Wm Rice

6. DATE OF BIRTH (MONTH, DAY AND YEAR) unknown

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, hrs. or min.
<u>4</u>	<u>79</u>			

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

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

10. NAME OF FATHER Don't know

11. BIRTHPLACE OF FATHER (CITY OR TOWN) Don't know
 (STATE OR COUNTRY) Don't know

12. MAIDEN NAME OF MOTHER Don't know

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

14. INFORMANT Mary Bridges
 (Address) 1116 W 25th Str.

FILED Feb 8 1929 W. S. James
 REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) March 6 1929

17. I HEREBY CERTIFY That I attended deceased from March 1, 1929, to March 6, 1929 that I last saw him alive on March 6, 1929, and that death occurred, on the date stated above, at 3 P.M.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Cardiac Decompensation
of Aortic Regurgitation
 (duration) yrs. mos. da.

CONTRIBUTORY (SECONDARY) Senility
 (duration) yrs. mos. da.

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 Physical Exam
 (Signed) J. W. Booker, M. D.
 (Address) 2128 Vine St.

*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 B.R. Cemetery DATE OF BURIAL 3-9-1929

20. UNDERTAKER Flynn & Greenstreet ADDRESS K.C. 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.
 48
 25
 1929
 235
 2
 31
 2

