33

MAY 24 1929

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

Do not use this space.

14283

1. PLACE OF DEATH

County Dent — Registration District No. 266 — File No.

Township Lynn — Primary Registration District No. 5369 — Registered No. X9

City (No. St. Ward)

2. FULL NAME Elisha O Rice

(a) Residence. No. St., Ward. (If nonresident give city or town and State)
(Usual place of abode)

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

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF: Adaline Rice

6. DATE OF BIRTH (MONTH, DAY AND YEAR): Apr. 4, 1845

7. AGE: Years 84 — Months — Days — 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: Don't know
11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY): Don't know
12. MAIDEN NAME OF MOTHER: Don't know
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY): Don't know

14. INFORMANT: C. L. Wells
(Address) Doss, Mo.

15. FILED 4/5, 1929 H. E. Rudd, Tw Lc
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR): April 4 1929

17. I HEREBY CERTIFY, That I attended deceased from Apr. 4, 1929, to X X, 19 that I last saw him alive on April 4, 1929, and that death occurred, on the date stated above, at 4 11 P m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Ulcer of Stomach
(duration) 35 yrs. mos. ds.

CONTRIBUTORY (SECONDARY): Infirmities of age
(duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH? X
DID AN OPERATION PRECEDE DEATH? X DATE OF
WAS THERE AN AUTOPSY? no
WHAT TEST CONFIRMED DIAGNOSIS? none

(Signed) J. C. Welch, M. D
, 19 (Address) Salem, 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: Miner Cemt — DATE OF BURIAL: 4/5 1929

20. UNDERTAKER: None — ADDRESS: —

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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.