

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

Do not use this space.

25929

1. PLACE OF DEATH

County Polk Registration District No. 701 File No. _____
 Township _____ Primary Registration District No. 4422 Registered No. 35-
 City Polina (No. _____) St. _____ Ward _____

2. FULL NAME Sarah E Rice

(a) Residence, No. _____ St. _____ Ward _____
 (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. (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX <u>Female</u>	4. COLOR OR RACE <u>White</u>	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) <u>Widowed</u>
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF <u>Jan Rice deceased</u>		
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) <u>July 4 1846</u>		
7. AGE	YEARS <u>85</u>	MONTHS <u>2</u>
	DAYS <u>24</u>	If LESS than 1 day, _____ hrs. or _____ min.
OCCUPATION	8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. <u>Housewife</u>	
	9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.	
	10. Date deceased last worked at this occupation (month and year)	11. Total time (years) spent in this occupation
12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>Columbia, Mo</u>		
FATHER	13. NAME <u>John McPherson</u>	
	14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>Scotland</u>	
MOTHER	15. MAIDEN NAME <u>Estell</u>	
	16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>Ky</u>	
17. INFORMANT <u>Vera Rice</u>		
18. BURIAL, CREMATION, OR REMOVAL PLACE <u>Greenwood</u> DATE <u>July 29 1931</u>		
19. UNDERTAKER <u>Hutchinson Blue</u>		
20. FILED <u>July 29 1931</u> <u>F. P. Roberts</u> Registrar.		

MEDICAL CERTIFICATE OF DEATH

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21. DATE OF DEATH (MONTH, DAY, AND YEAR) July 28 1931

22. I HEREBY CERTIFY, that I attended deceased from 7-15, 1931, to 7-28, 1931.
 I last saw her alive on 7-28, 1931. Death is said to have occurred on the date stated above, at 11.00 a.m.
 The principal cause of death and related causes of importance were as follows:
Chronic myocarditis
fractured hip
terminal hypostatic pneumonia
 Date of onset 1928
1 week

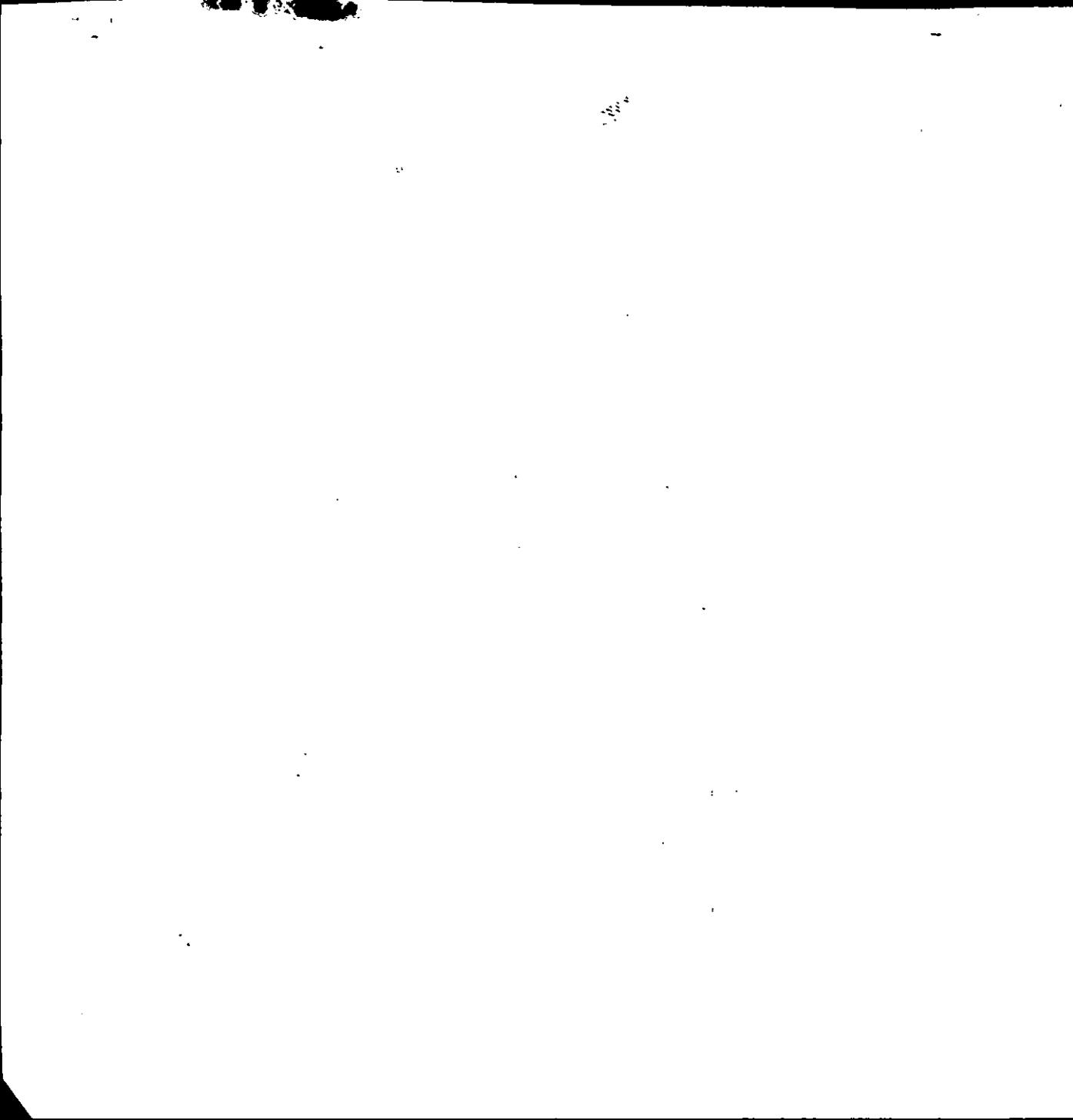
Other contributory causes of importance:
196A
194B
532

Name of operation _____ Date of _____
 What test confirmed diagnosis? _____ Was there an autopsy? _____

23. If death was due to external causes (violence), fill in also the following:
 Accident, suicide, or homicide? _____ Date of injury _____, 19____
 Where did injury occur? _____ (Specify city or town, county, and State)
 Specify whether injury occurred in industry, in home, or in public place.

Manner of injury _____
 Nature of injury _____

24. Was disease or injury in any way related to occupation of deceased? _____
 If so, specify _____
 (Signed) Doyle C. McCrawns, M. D.
 (Address) Polina Mo



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ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

1. PLACE OF DEATH

County Polk
Township _____
City Polwar (No. _____)

Registration District No. 901
Primary Registration District No. 4422

File No. _____
Registered No. 35
St. _____ Ward _____

2. FULL NAME

Sarah E. 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 F 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) wid

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

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

7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min.

OCCUPATION

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc.
9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.
10. Date deceased last worked at this occupation (month and year) _____

11. Total time (years) spent in this occupation _____

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

13. NAME

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

15. MAIDEN NAME

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

17. INFORMANT (ADDRESS)

18. BURIAL, CREMATION, OR REMOVAL PLACE _____ DATE _____ 19 _____

19. UNDERTAKER (ADDRESS)

20. FILED July 29, 1931 J. Robert Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) July 28, 1931

22. I HEREBY CERTIFY, That I attended deceased from _____ to _____, 19____

I last saw h. _____ alive on _____, 19____. Death is said to have occurred on the date stated above, at _____ m.

The principal cause of death and related causes of importance were as follows:

Chronic myocarditis (Date of onset 2/1930)
Fractured hip
Tubercular hypostatic pneumonia (Date of onset July 20, 31)

Other contributory causes of importance:

Brain fall
1860

Name of operation _____ Date of _____
What test confirmed diagnosis? _____ Was there an autopsy? _____

23. If death was due to external causes (violence), fill in also the following: Accident, suicide, or homicide? Accident Date of injury Oct, 1931
Where did injury occur? at home (Specify city or town, county, and State)
Specify whether injury occurred in industry, in home, or in public place.

Manner of injury Brain fall
Nature of injury Fractured hip

24. Was disease or injury in any way related to occupation of deceased? No
If so, specify _____

(Signed) _____, M. D.
(Address) _____

SUPPLEMENTARY

REGISTRATION SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW

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

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