

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.

FEB 25 1935

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

Do not use this space.

1. PLACE OF DEATH

County Iron
Township Iron
City Graniteville (No.)

Registration District No. 11 6-9
Primary Registration District No. 6-6-49

File No. 1100
Registered No. 1
St. Ward)

2. FULL NAME Samuel Franklin Rice

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

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 Flora Rice

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Dec. 27th 1867

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
67 0 14

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. Farmer
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) 1934 11. Total time (years) spent in this occupation

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

13. NAME Joseph P. Rice

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

15. MAIDEN NAME Unknown

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

17. INFORMANT R. R. Rice (ADDRESS) Graniteville Mo.

18. BURIAL, CREMATION, OR REMOVAL
PLACE Bellevue Mo. DATE Jan. 13, 1935

19. UNDERTAKER White & Son (ADDRESS) Ironton Mo.

20. FILED Jan 26, 1935 Wm A Tompkins Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Jan. 11, 1935

22. I HEREBY CERTIFY, That I attended deceased from Jan 10, 1935 to Jan 11, 1935
I last saw him alive on Jan 10, 1935 Death is said to have occurred on the date stated above, at 2:00 P.M.

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

Infection of sub-lingual glands and adjacent lymphatics
11/2/35

Date of onset
1/4/35
1/11/35

Other contributory causes of importance:

Eubolemia

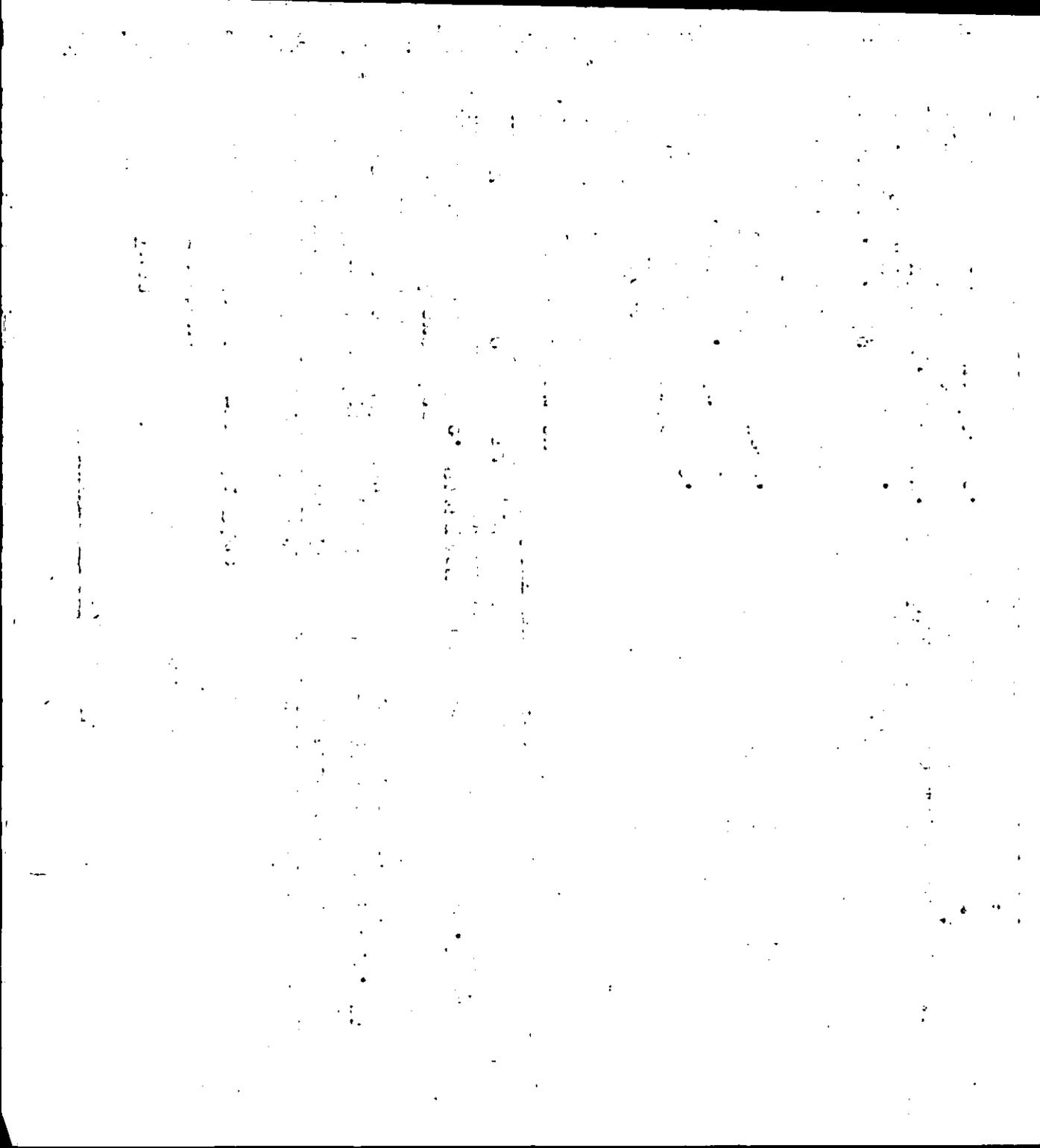
Name of operation Date of
What test confirmed diagnosis? Was there an autopsy?

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? no
If so, specify W. G. Tison (Signed), M. D.

(Address) Ironton Mo



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

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

1. PLACE OF DEATH

County Iron
Township Iron
City _____ (No. _____)

Registration District No. 1159
Primary Registration District No. 55-49

File No. _____
Registered No. 1
St. _____ Ward _____

2. FULL NAME

Samuel Franklin 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 foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX m | 4. COLOR OR RACE w | 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) w

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Jan 11, 1935

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

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

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

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

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

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

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc.

Infection of sub-lingual lymphatics Date of onset _____

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.

Tubercle from advanced pyorrhea 115-49

10. Date deceased last worked at this occupation (month and year)

11. Total time (years) spent in this occupation

Other contributory causes of importance:

Embolism
Cardiac

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

13. NAME

Name of operation _____ Date of _____

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

What test confirmed diagnosis? _____ Was there an autopsy? _____

15. MAIDEN NAME

23. If death was due to external causes (violence), fill in also the following: Accident, suicide, or homicide? _____ Date of injury _____, 19____

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

Where did injury occur? _____ (Specify city or town, county, and State)

17. INFORMANT (ADDRESS)

Specify whether injury occurred in industry, in home, or in public place.

18. BURIAL, CREMATION, OR REMOVAL

Manner of injury _____

PLACE _____ DATE _____, 19____

Nature of injury _____

19. UNDERTAKER (ADDRESS)

24. Was disease or injury in any way related to occupation of deceased? _____

If so, specify _____

20. FILED April 4, 1935 Mrs W A Townsend (Address) _____

(Signed) _____, M. D.

Registrar

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAW. Exact statement of OCCUPATION is very important.

