

FEB 20 1936

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

Do not use this space.

1625

1. PLACE OF DEATH

County Jackson
Township Scott
City Kansas City (No. 100)

Registration District No. 399
Primary Registration District No. 100
Trinity Lutheran

File No. _____
Registered No. 470
Ward _____

2. FULL NAME

James J. Rice
(a) Residence, No. Verona Mo. 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 M 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Married

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Apr 16 86

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
49 9 14

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

13. NAME Celestia E. Rice

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

15. MAIDEN NAME Susan M. Horner

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

17. INFORMANT (ADDRESS) Family Hosp

18. BURIAL, CREMATION, OR REMOVAL PLACE Verona Mo DATE Feb 1st 36

19. UNDERTAKER (ADDRESS) Mrs. G. L. Foster

20. FILED 1-30 1936 J. M. Brown Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Jan 30 1936

22. I HEREBY CERTIFY That I attended deceased from Jan 25 1936 to Jan 30 1936
I last saw h. alive on Jan 25 1936 Death is said to have occurred on the date stated above, at 9:30 a.m.
The principal cause of death and related causes of importance were as follows:

Bumelo pneumonia
Secondary malnutrition
maxillary carcinoma
Date of onset 1-27-36

Name of operation None Date of _____
What test confirmed diagnosis System 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) Wm. Sidman Spear M. D.
(Address) 430 1/2 Dean

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.

