

AUG - 5 1937

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

Do not use this space.

## 1. PLACE OF DEATH

County.....

Registration District No.....

791

Township.....  
St. Louis

Primary Registration District No.....

City Hospital No. 11008

City..... (No.....)

File No.....

25628

Registered No.....

6802

St..... Ward.....

C. 4608

William Rice

## 2. FULL NAME

(a) Residence, No. 3309 a Magnolia St., 17 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

## MEDICAL CERTIFICATE OF DEATH

3. SEX male	4. COLOR OR RACE white	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) married
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21. DATE OF DEATH (MONTH, DAY, AND YEAR) 7/14/37, 19

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

22. I HEREBY CERTIFY, That I attended deceased from  
7/5/37, 19, to 7/14/37, 19.....  
I last saw him alive on 7/14/37, 19..... Death is said  
to have occurred on the date stated above, at 0. p. m.  
The principal cause of death and related causes of importance were as follows:

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Sept 17, 1906	7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, hrs. or min.
	30		9	27	

Date of onset

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

*Tuberculosis*  
*Pneumonia*

Other contributory causes of importance:  
*J.S.*

12. BIRTHPLACE (CITY OR TOWN)..... St. Louis, Missouri  
(STATE OR COUNTRY)

13. NAME Patrick Rice

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

15. MAIDEN NAME Catherine ?

16. BIRTHPLACE (CITY OR TOWN)..... Ireland  
(STATE OR COUNTRY)17. INFORMANT..... Hosp. Info M. Kent  
(ADDRESS)18. BURIAL, CREMATION, OR REMOVAL  
PLACE Calvary DATE July 17, 193719. UNDERTAKER.....  
(ADDRESS) 1519 S. Grand20. FILE JUL 15 1937 J. J. Bredeck  
Registrar.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 Chas. J. Fanning M. D.  
(Signed) City Hospital No. 1  
(Address)

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

81  
442  
15  
15

6105

Mable Hubbard