

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.

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

33019

Do not use this space.

## 1. PLACE OF DEATH

(a) County..... Registration District No. **791**  
(b) Township..... Primary Registration District No. **1003**  
(c) City **St Louis** (d) Street No. **Mo Baptist Hospital** St.  
(If death occurred in Hospital or Institution, write its name instead of street and number)  
(e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

## 2. PRINT FULL NAME

**Fraudie F Rice**  
(a) Residence, No. **3960a St Louis Ave.** St. **III**  
(Usual place of abode, if no street address, write county or city) (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) **Married**

5A. IF MARRIED, WIDOWED, OR DIVORCED  
HUSBAND OF **Hattie Claywell Rice**  
(OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) **Nov 25 1887**

7. AGE YEARS **49** MONTHS **10** DAYS **2** IF LESS than 1 day, ..... hrs. or ..... min.

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. **Traveling Freight Agent**  
9. Industry or business in which work was done, as saw mill, bank, etc. **B & O R R**  
10. Date deceased last worked at this occupation (month and year)..... 11. Total time (years) spent in this occupation.....

12. BIRTHPLACE (CITY OR TOWN) **Louisiana** (STATE OR COUNTRY) **Mo**

13. NAME **Marion Rice**  
14. BIRTHPLACE (CITY OR TOWN) **Kentucky** (STATE OR COUNTRY)

15. MAIDEN NAME **Effie Hogg**  
16. BIRTHPLACE (CITY OR TOWN) **Missouri** (STATE OR COUNTRY)

17. INFORMANT **Hattie Rice** (ADDRESS) **3960 St Louis Ave**

18. BURIAL, CREMATION, OR REMOVAL  
PLACE **East St Louis Ill** **Sept 30 1937**

19. FUNERAL DIRECTOR **Beiderwieden Funeral Home** (ADDRESS) **1936 St Louis Ave** Inc

20. FILED **SEP 23 1937** **J. J. Bredeck** Local Registrar.

## MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) **Sept. 27 1937**

22. I HEREBY CERTIFY, That I attended deceased from **1936** to **Sept 27 1937**

I last saw him alive on **Sept 27 1937** Death is said to have occurred on the date stated above, at **4:00 PM**

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

**Undercard of liver**  
**operation for removal of gall bladder unknown**  
**to be returned**

Name of operation **Wholesale** Date of operation **Sept 1936**  
What test confirmed diagnosis? **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) **J. J. Bredeck** M. D.  
(Address) **1936 St Louis Ave**

STATEMENT BY LICENSED EMBALMER

I, R. W. Holz

Licensed Embalmer No. 3737

hereby certify that the body recorded on the reverse side of this certificate was embalmed by me

L. E.

No. \_\_\_\_\_ or by \_\_\_\_\_  
working under my personal supervision.

Registered Apprentice No. \_\_\_\_\_

Signed G. Holz

Licensed Embalmer No. 3737

**Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)**