

APR 10 1939

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

10327
Do not use this space.

1. PLACE OF DEATH

(a) County Cape Girardeau Registration District No. 121
(b) Township 11 Primary Registration District No. 3009 Registered No. 81
(c) City Cape Girardeau (d) Street No. St. Francis 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. 9 How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME

(a) Residence, No. 20 Grene Elizabeth Rice St. Lipsay Mo
(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 Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) married

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Mar 2 - 1907

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
32 0 2

OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. House Keeper
9. Industry or business in which work was done, as 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) Wayne Co Mo

FATHER 13. NAME Geo. T. Meador

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Wayne Co Mo

MOTHER 15. MAIDEN NAME Maud Hoard

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

17. INFORMANT (ADDRESS) Herbert Rice
Lipsay, Mo.

18. BURIAL, CREMATION, OR REMOVAL PLACE Lipsay DATE Mar 6 1939

19. FUNERAL DIRECTOR (NAME) (ADDRESS) Washing F & N Co
Cape Girardeau

20. FILED 3 - 4 1939 J. M. Thompson
Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Mar 4 1939

22. I HEREBY CERTIFY, That I attended deceased from Feb. 26, 1939, to Mar 4, 1939

I last saw her alive on Mar 4, 1939. 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:

Brain abscess

Date of onset

Other contributory causes of importance:

Name of operation none Date of

What test confirmed diagnosis? Sputum Was there an autopsy? no

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 _____

(Signed) Dean J. Ogden, M. D.

(Address) Cape Girardeau Mo

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.

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STATE OF CALIFORNIA
DEPARTMENT OF HEALTH
DIVISION OF ANATOMY

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,

C. J. Lorberg

or by _____

Registered Apprentice No. _____, working under my personal supervision.

Signed _____

C. J. Lorberg

Licensed Embalmer No. 3810

P. O. Address Cape Girardeau

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.)

If this body is not embalmed, above space should be left blank.

FILL IN ANSWERS TO ALL SPACES
CHECKED IN RED PENCIL.

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

10 327

Do not use this space.

1. PLACE OF DEATH

(a) County Cape Girardeau Registration District No. 125
(b) Township 9 Primary Registration District No. 3009 Registered No. _____
(c) City Cape G (d) Street No. _____ 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 Irene Elizabeth Rice

(a) Residence, No. _____ St. (If nonresident, give city or town and State)
(Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX 7 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) m

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 3-4, 1939

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 h. _____ 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 sawyer, bookkeeper, etc.
9. Industry or business in which work was done, as saw mill, bank, etc.
10. Date deceased last worked at this occupation (month and year)
11. Total time (years) spent in this occupation

Brain abscess
g/n

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

Other contributory causes of importance:
Probably secondary to suppurative chronic otitis media

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. FUNERAL DIRECTOR (ADDRESS)

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

20. FILED _____, 19____

If so, specify _____ (Signed) _____, M. D.

(Address) Cape Girardeau

Local Registrar

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

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAW.

100-3-123