DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
JAN 12 1940

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 42116

Registration District No. _____ Primary Registration District No. _____ Registrar's No. 11239

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.

1. PLACE OF DEATH: 1

(a) County _____

(b) City or town St. Louis
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: S.t Anthony Hospital
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution _____ (Specify whether years, months or days)
In this community 4625 Idaho Ave.

2. USUAL RESIDENCE OF DECEASED: 1

(a) State Missouri (b) County _____

(c) City or town St Louis 15
(If outside city or town limits, write "RURAL")

(d) Street No. 4625 Idaho Ave.
(If rural, give location)

(e) If foreign born, how long in U. S. A.? _____ years.

3. (a) PRINT FULL NAME Luther A Rice 202

3. (b) If veteran, name war World War

3. (c) Social Security No. 494-07-0760

4. Sex Male

5. Color or race White

6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Lillie Rice

6. (c) Age of husband or wife if alive 54 years

7. Birth date of deceased Aug. 27 1879 (Month) (Day) (Year)

8. AGE: Years	Months	Days	If less than one day
60	4	2	____ hr. ____ min.

9. Birthplace Missouri (City, town, or county) (State or foreign country)

10. Usual occupation Electric Lineman

11. Industry or business Union Electric Co C

FATHER
12. Name Marion Rice
13. Birthplace Missouri (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name Susan Evans
15. Birthplace Missouri (City, town, or county) (State or foreign country)

16. (a) Informant's own signature Lillies Rice
(b) Address 4625 Idaho Ave.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan 2/40 (Month) (Day) (Year)
(c) Place: burial or cremation Sun Set Park

18. (a) Signature of funeral director Thos Lutes
(b) Address 2906 Gravois Ave.

19. (a) DEC 31 1939 (Date received local registrar) (b) J. F. Bredrick (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec day 29 year 1939 hour 11 30 P.M. minute _____ M.

21. I hereby certify that I attended the deceased from Dec 16 1939, 19__ to Dec 29 1939; that I last saw him alive on Dec 29 1939 and that death occurred on the date and hour stated above.

Immediate cause of death	Duration
Acute cholecystitis	13 da
Acute Pancreatitis	13 da
Due to Diagnosis	
Due to	
Other conditions Cholelithiasis (Include pregnancy within 3 months of death)	5 yr

Major findings:
Of operations _____
Of autopsy None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify) _____
(b) Date of occurrence _____
(c) Where did injury occur? _____ (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____ (Specify type of place)
While at work? _____ (e) Means of injury _____

23. Signature H. E. Kingsbury (M. D. or other)
Address 3603 Humphrey St. Date signed 12-30-39
St Louis Mo

(Licensed Embalmer's Statement on Reverse Side)

3603 Kemp Lane

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, or by

Thos Little, Registered Apprentice No.

working under my personal supervision.

Signed Thos Little

Licensed Embalmer No. 1619

P. O. Address 2906 Travis

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

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