

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

44928  
Do not use this space.

1. PLACE OF DEATH

(a) County Jefferson Registration District No. 875

(b) Township Washington Primary Registration District No. 6167 Registered No. 312

(c) City Neuda (d) Street No. Wall St. # 3 St.

(e) Length of residence in city or town where death occurred 6 yrs. 3 mos. 1 da. (f) How long in U. S., if of foreign birth? yrs. mos. da.

2. PRINT FULL NAME Jacob O Rice

(a) Residence, No. Green Ridge, MO St.  (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) Wid

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) July 20 '58

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

81 5 8

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Janitor

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) DK 11. Total time (years) spent in this occupation

**MEDICAL CERTIFICATE OF DEATH**

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 12-28-1939

22. I HEREBY CERTIFY, That I attended deceased from Jan 1, 1939, to Dec 28, 1939

I last saw him alive on Dec 27, 1939 Death is said to have occurred on the date stated above, at 8:30 a. m.

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

Acute myocarditis & m. degenerated

Date of onset DK

Other contributory causes of importance: Senility

Name of operation..... Date of.....

What test confirmed diagnosis?..... 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

Also, specify Jacob O Rice, M. D.

(Signed) Jacob O Rice (Address) Neuda, MO

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

13. NAME DK

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

15. MAIDEN NAME DK

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

17. INFORMANT (ADDRESS) Keep Records

18. BURIAL, CREMATION, OR REMOVAL

PLACE Sedalia, Mo DATE Dec 30, 1939

19. FUNERAL DIRECTOR (NAME) (ADDRESS) Ewing Funeral Home, Sedalia, Missouri

20. FILED Dec 28, 1939 Allen V. Hays Local Registrar.

WRITE PLAINLY, WITH UNFADING INK---THIS IS A PERMANENT RECORD

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.

RECEIVED

District Health Officer No. 7;

District File Number 7-40-20

Date Filed 1-9-40

**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.....

....., Registered Apprentice No.....

working under my personal supervision.

Signed Ruane Ewing

Licensed Embalmer No. 38747

P. O. Address Sedalia Mo.

**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.**