

FILED SEP 19 1940
FILED AUG 19 1940

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 28214

Registration District No. 149

Primary Registration District No. 4683

Registrar's No. 4

1. PLACE OF DEATH:

(a) County Cass

(b) City or town Cleveland Mo
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:
(If not in hospital or institution, write street number or location) 2

(d) Length of stay: In hospital or institution _____
(Specify whether)

In this community 46 years
years, months or days yes

3. (a) PRINT FULL NAME FRANKLIN RANDOLPH RICE

3. (b) If veteran, name war _____

3. (c) Social Security No. _____

4. Sex Male

5. Color or race White

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

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

6. (c) Age of husband or wife if alive 74 years

7. Birth date of deceased Aug 8 1865
(Month) (Day) (Year)

8. AGE: Years 76 Months 11 Days 23
If less than one day hr. _____ min.

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

10. Usual occupation Farmer

11. Industry or business _____

MOTHER FATHER { 12. Name George Rice 9

13. Birthplace Unknown
(City, town or county) (State or foreign country)

14. Maiden name Elizabeth Palmer

15. Birthplace Iowa
(City, town, or county) (State or foreign country)

16. (a) Informant Laura Rice

(b) Address Cleveland Mo.

17. (a) Burial (b) Date thereof Aug 3-1940
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Isbern Field

18. (a) Signature of funeral director W. C. Myers

(b) Address Cleveland Mo.

19. (a) Aug 3 (b) W. C. Myers
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Cass

(c) City or town Cleveland
(If outside city or town limits, write "RURAL")

(d) Street No. _____
(If rural, give location)

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month August day 1
year 1940 hour 7 minute 40 A.M.

21. I hereby certify that I attended the deceased from July 9, 1939 to August 1, 1940; that I last saw him alive on July 29, 1940 and that death occurred on the date and hour stated above.

Immediate cause of death Encephalomalacia

Due to Cerebral hemorrhage

Due to Hypertension

Other conditions Arterio sclerosis
(Include pregnancy within 3 months of death)

Duration
<u>1 Mo.</u>
<u>1 Yr.</u>
<u>2 Yr.</u>

PHYSICIAN _____

Major findings: _____

Of operations. _____

Of autopsy. _____

J. W. Moore

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? Yes

While at work? _____
(Specify type of place)

(e) Means of injury _____

23. Signature W. C. Moore (M. D. of other _____)

Address Cleveland Mo. Date signed 8/2/40

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

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.....

Licensed Embalmer No. *2517*

P. O. Address *Cleveland, Ohio*

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.