

7-39  
X21492

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

Dr. Mc Blugh  
Sikeston,  
DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

39346

Registration District No. 604 Primary Registration District No. 5502 Registrar's No. 0

1. PLACE OF DEATH: New Madrid  
(a) County: New Madrid  
(b) City or town: Rural  
(c) Name of hospital or institution:  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 15 yrs  
In this community 15 yrs  
years, months or days

3. (a) PRINT FULL NAME: C. C. RICE  
3. (b) If veteran, name war: ✓  
3. (c) Social Security No.: none

4. Sex: Male  
5. Color or race: W  
6. (a) Single, widowed, married, divorced: Single  
6. (b) Name of husband or wife:  
6. (c) Age of husband or wife if alive: \_\_\_\_\_ years  
7. Birth date of deceased: Dec. 12, 1882  
(Month) (Day) (Year)

8. AGE: Years 57 Months 8 Days 20  
If less than one day hr. min.

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

10. Usual occupation: Farming

11. Industry or business:  
12. Name: Ben Rice  
13. Birthplace: Indiana  
(City, town, or county) (State or foreign country)  
14. Maiden name: 0  
15. Birthplace: 0  
(City, town, or county) (State or foreign country)

16. (a) Informant: Mrs. Gassie Nelson  
(b) Address: Matthews, Mo

17. (a) Burial (b) Date thereof: 9/3/40  
(Burial, cremation, or removal) (Month) (Day) (Year)  
(c) Place: burial or cremation: Priner, Sikeston

18. (a) Signature of funeral director: Travis Shelby  
(b) Address: East Sikeston, Mo

19. (a) \_\_\_\_\_ (b) \_\_\_\_\_  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:  
(a) State: Missouri (b) County: New Madrid  
(c) City or town: Rural  
(If outside city or town limits, write "RURAL")  
(d) Street No.: 3 miles N.W. of Newance  
(If rural, give location)  
(e) If foreign born, how long in U. S. A.? \_\_\_\_\_ years.

MEDICAL CERTIFICATION  
20. DATE OF DEATH: Month Sept day 2  
year 1940 hour 11 minute 9 M.

21. I hereby certify that I attended the deceased from 12-21-36  
to Aug 17, 1940  
that I last saw him alive on Aug 17, 1940  
and that death occurred on the date and hour stated above.

Immediate cause of death: Chronic Cardiac Valvular Disease  
Duration: 5 yrs

Due to: \_\_\_\_\_  
Due to: \_\_\_\_\_

Other conditions: Vascular Hypertension  
(Include pregnancy within 3 months of death)  
Major findings: \_\_\_\_\_  
Of operations: \_\_\_\_\_  
Of autopsy: \_\_\_\_\_

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?  
533  
While at work? \_\_\_\_\_ (Specify type of place)  
(e) Means of injury: \_\_\_\_\_  
23. Signature: Thomas C. McClain (M. D. or other) \_\_\_\_\_  
Address: Sikeston, Mo Date signed: 9-7-40

RECEIVED

District Health Officer No.

District File Number 1240-17

Date Filed 12/12/40

**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 Travis Shelby

Licensed Embalmer No. 2720

P. O. Address East Prairie

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

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

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. 39346  
Registrar's No. \_\_\_\_\_

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

Registration District No. 604

Primary Registration District No. 5802

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

1. PLACE OF DEATH:

(a) County New Madrid  
(b) City or town New Madrid T.P.  
(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)  
(d) Length of stay: In hospital or institution \_\_\_\_\_  
In this community 50 yrs (Specify whether years, months or days)

3. (a) PRINT FULL NAME C. Rice

3. (b) If veteran, name war   
3. (c) Social Security No. None

4. Sex M 5. Color or race W  
6. (a) Single, widowed, married, divorced S

6. (b) Name of husband or wife \_\_\_\_\_  
6. (c) Age of husband, or wife, if alive \_\_\_\_\_ year

7. Birth date of deceased Dec 12 1882  
(Month) (Day) (Year)

8. AGE: Years 57 Months 8 Days 20  
If less than one day \_\_\_\_\_ hr \_\_\_\_\_ min

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

10. Usual occupation Farming

11. Industry or business \_\_\_\_\_

12. Name Ben Rice

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

14. Maiden name Cassie Nelson

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

16. (a) Informant Mrs Cassie Nelson  
(b) Address Matthews mo

17. (a) Burial (b) Date thereof 9/3/1940  
(Burial, cremation, or removal) (Month) (Day) (Year)

18. (a) Signature of funeral director Travis Shelby  
(b) Address East Prairie mo

19. (a) 2/7/41 (b) Wm O'Bannon  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State mo (b) County New Madrid  
(c) City or town Rural  
(If outside city or town limits write "RURAL")  
(d) Street No. 3 mi West of Keavance  
(If rural, give location)  
(e) If foreign born, how long in U. S. A.? \_\_\_\_\_ years

MEDICAL CERTIFICATION

20. DATE OF DEATH Month 9 day 2  
year 1940 hour \_\_\_\_\_ minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_, 19\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_;  
that I last saw h \_\_\_\_\_ alive on \_\_\_\_\_, 19\_\_\_\_;  
and that death occurred on the date and hour stated above.

Immediate cause of death Chronic Cardiac  
Valvular disease

Due to \_\_\_\_\_  
Due to \_\_\_\_\_

Other conditions Vascular Hypertension  
(Include pregnancy within 3 months of death)

Major findings:  
Of operations \_\_\_\_\_  
Of autopsy \_\_\_\_\_

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 \_\_\_\_\_  
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?

While at work? \_\_\_\_\_ (Specify type of place)  
(e) Means of injury \_\_\_\_\_

23. Signature Thos C. McClure (M. D. or other)  
Address Sikeston mo Date signed \_\_\_\_\_

S-39346 1940

family says deceased always  
at by the name of C. C. Rice  
& no other name was  
ever used.

Shelby And. Co