V. S. No. 2
00M—2-43
5-17-39
I X35897

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 17114

FILED JUN 1943

Registration District No. 1002 — Primary Registration District No. 1002 — Registrar's No. 2086

1. PLACE OF DEATH:

(a) County: Jackson

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

(c) Name of hospital or institution: 2609 Anne Ct. (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: 20 yrs

2. USUAL RESIDENCE OF DECEASED:

(a) State: Missouri (b) County: Jackson

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

(d) Street No.: 2609 Anne Ct. (If rural, give location)

(e) Citizen of foreign country? ____ (Yes or No)

If yes, name country ____

3. (a) PRINT FULL NAME: MRS. CATHERINE RICE

3. (b) If veteran, name war: no

3. (c) Social Security No.: none

4. Sex: Female

5. Color or race: Wht

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

6. (b) Name of husband or wife: Robert L. Rice

6. (c) Age of husband or wife if alive: 80 years

7. Birth date of deceased: Feb (Month) 13 (Day) 1873 (Year)

8. AGE: Years 70 | Months 2 | Days 19 | If less than one day ____ hr. ____ min.

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

10. Usual occupation: house wife.

11. Industry or business: ____

FATHER
12. Name: Wm Hickey
13. Birthplace: Cork Co. (City, town, or county) Ireland (State or foreign country)

MOTHER
14. Maiden name: Bridgett Lanahan
15. Birthplace: Marshel (City, town, or county) Scotland (State or foreign country)

16. (a) Informant: Marjorie Moran
(b) Address: 2609 Anne Ct.

17. (a) Removal (Burial, cremation, or removal) (b) Date thereof: 5-4-43 (Month) (Day) (Year)
(c) Place: burial or cremation: Sioux City, Iowa

18. (a) Signature of funeral director: Herbert Funeral Home
(b) Address: 2332 Montgomery

19. (a) 5-4-43 (Date received local registrar) (b) M. M. Grove (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 21 year 1943 hour ____ minute ____ M.

21. I hereby certify that I attended the deceased from 4/11/43 to 5/2/43 19__ and that I last saw her alive on 5/2/43 19__ and that death occurred on the date and hour stated above.

Immediate cause of death: Carcinomatosis with Sigmoid with Duration ?

Due to: Recidivey Carcinomatosis Duration ?

Other conditions (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 ____
(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: [illegible] (M. D. or other)
Address: [illegible] Date signed 5-3-43

(Licensed Embalmer's Statement on Reverse Side)

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 Oscar Samuelson

Licensed Embalmer No. 3002

P. O. Address 2332 Monroe Place

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, fact should be so stated above.