

No. 2
-2-43
17-39
X35697

FILED OCT 13 1943 149

Registration District No. 149

Primary Registration District No. 1002

State File No. _____
Registrar's No. 4203

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:
K. C. General Hospital No. 10
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 13 days
(Specify whether
In this community 68 years
years, months or days)

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. 4816 E. 8 St.
(If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME Alfred Rice

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

4. Sex Male 5. Color or race White
6. (a) Single, widowed, married, divorced Widowed
6. (b) Name of husband or wife Mrs. D. Rice
6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased Sept 16, 1875
(Month) (Day) (Year)

8. AGE: 68 Years 0 Months 13 Days
If less than one day hr. _____ min.

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

10. Usual occupation Painting Contractor

11. Industry or business _____

12. Name Frederick S. Rice
13. Birthplace unknown (City, town, or county) (State or foreign country)
14. Maiden name Anna Hoover
15. Birthplace unknown (City, town, or county) (State or foreign country)

16. (a) Informant Ernest J. Rice
(b) Address 4816 East 8th
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-2-43
(Month) (Day) (Year)
(c) Place: burial or cremation Woodlawn Cem

18. (a) Signature of funeral director W. E. Brown
(b) Address Independence, Mo
19. (a) 10-2-43 (Date received local registrar) (b) W. E. Brown (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept. day 29th
year 1943 hour 8 minute P. M.

21. I hereby certify that I attended the deceased from Sept. 16th 1943 to Sept. 29th 1943
that I last saw him alive on Sept. 29th 1943
and that death occurred on the date and hour stated above.

Immediate cause of death Uremia ✓
Due to _____
Due to _____
Other conditions (Include pregnancy within 3 months of death) _____

Major findings: Of operations _____
Of autopsy See above

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?
While at work? _____ (Specify type of place) (e) Means of injury _____
23. Signature Ernest J. Rice (M. D. or other) _____
Address Med. Dir. Gen'l Hosp. Date signed 9-30-43

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

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

MOTHER FATHER

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.....

George C. Cassard

Licensed Embalmer No.....

2249

P. O. Address.....

Independence, 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, fact should be so stated above.

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

FILED OCT

State File No. _____

Registrar's No. 4283

Registration District No. 149

Primary Registration District No. 1062

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

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:
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution _____ (Specify whether
 In this community _____ (Specify whether
 years, months or days)

3. (a) PRINT FULL NAME

Alfred Paris

3. (b) If veteran, name war _____

3. (c) Social Security No. _____

4. Sex m 5. Color or race w
 6. (a) Single, widowed, married, divorced w

6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased Sept 16 1906
 (Month) (Day) (Year)

8. AGE: Years 68 Months 0 Days _____ (If less than one day, _____ min.)

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

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER

12. Name _____

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

14. Maiden name _____

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

16. (a) Informant _____

(b) Address _____

17. (a) _____ (b) Date thereof _____ (Month) (Day) (Year)
 (Burial, cremation, or removal)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

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

2. USUAL RESIDENCE OF DECEASED:

(a) State _____ (b) County _____
 (c) City or town _____ (If outside city or town limits, write "RURAL")
 (d) Street No. _____ (If rural, give location)
 (e) Citizen of foreign country? _____ (Yes or No)
 If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept day 12 year 1943 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____, 19____; that I last saw him/her alive on _____, 19____; and that death occurred on the date and hour stated above. Immediate cause of death thromb Duration _____

Due to Chronic Arteriosclerotic

Due to Nephritis

Other conditions _____ (Include pregnancy within 3 months of death)

Major findings: Of operations _____ 131a 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? _____

While at work? _____ (Specify type of place) (c) Means of injury _____

23. Signature _____ (M. D. or other) _____

Address _____ Date signed _____

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