

Registration District No. **184**

Primary Registration District No. **3038**

1. PLACE OF DEATH:

(a) County **Linn**
(b) City or town **Brookfield**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
211 East Canal Street
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether)
In this community **55 years**
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **Linn**
(c) City or town **Brookfield**
(If outside city or town limits, write "RURAL.")
(d) Street No. **211 East Canal Street**
(If rural, give location)
(e) Citizen of foreign country? **No** (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME **GLENN MORTON RICE**

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

4. Sex **M** 5. Color or race **W** 6. (a) Single, widowed, married, divorced **M**
6. (b) Name of husband or wife **Mary Logue Rice** 6. (c) Age of husband or wife if alive **54** years
7. Birth date of deceased **July 22, 1888**
(Month) (Day) (Year)

8. AGE: Years **55** Months **3** Days **18** If less than one day _____ hr. _____ min.

9. Birthplace **Brookfield, Missouri**
(City, town, or county) (State or foreign country)

10. Usual occupation **Building Contractor**

11. Industry or business **Concrete - Stonemason**

MOTHER FATHER { 12. Name **J. W. Rice**
13. Birthplace **Illinois**
(City, town, or county) (State or foreign country)
14. Maiden name **Mary A. Gray**
15. Birthplace **Indiana**
(City, town, or county) (State or foreign country)

16. (a) Informant: **Mrs. Mary Rice**
(b) Address **Brookfield, Mo.**

17. (a) **Burial** (b) Date thereof **Nov. 12, 1943**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Rose Hill Cemetery**

18. (a) Signature of funeral director **Rust Funeral Home**

(b) Address **Brookfield, Mo.**

19. (a) **11-12-1943** (b) **W. H. Ceman**
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **November** Day **10**
year **1943** hour **7** minute **30 a. m.**

21. I hereby certify that I attended the deceased from **October 29, 1943** to **Nov 10, 1943**
that I last saw him alive on **Nov. 10, 1943**
and that death occurred on the date and hour stated above.

Immediate cause of death **Cerebral Broncho pneumonia**
Menstruocaine
Due to **Hypertensive Heart Disease**
Due to **Cardiac Dilatation**

Duration

2 wks

5 yrs

4 da

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations _____

Of autopsy _____

93d

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) (e) Means of injury _____

23. Signature **Roy P. H. Taylor** (M. D. or other) **M.D.**
Address **Brookfield Mo.** Date signed **11/11/43**

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

456

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.....

H. Be Wright

Licensed Embalmer No.....

3718

P. O. Address.....

Brookfield, 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.