

Registration District No. \_\_\_\_\_ Primary Registration District No. \_\_\_\_\_

1. PLACE OF DEATH:

(a) County St. Louis

(b) City or town St. Louis  
(If outside city or town limits, write "RURAL" and name of township)

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

(d) Length of stay: In hospital or institution 1 yr  
(Specify whether years, months or days)

In this community 0  
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County St. Louis

(c) City or town St. Louis  
(If outside city or town limits, write "RURAL")

(d) Street No. City Sanitorium  
(If rural, give location)

(e) Citizen of foreign country? 0 (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME James B Rice

3. (b) If veteran, name war none

3. (c) Social Security No. unk

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov. day 23  
year 1944 hour 2:20 minute 30P M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_, 19\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_;

4. Sex m 5. Color or race W

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

6. (b) Name of husband or wife Una 6. (c) Age of husband or wife if alive 54 years

7. Birth date of deceased 10 7 1884  
(Month) (Day) (Year)

that I last saw h\_\_\_\_\_ alive on \_\_\_\_\_, 19\_\_\_\_; and that death occurred on the date and hour stated above.

Immediate cause of death Tobacco Pneumonia

8. AGE: Years Months Days If less than one day

60	1	16	hr. _____ min.
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Due to trip right to emergency treatment on Hall J. 2 Sanitorium Ground

Due to 4:00 P.M. Nov 19, 1944

Other conditions 186  
(Include pregnancy within 3 months of death)

9. Birthplace Carthage Ill 1  
(City, town, or county) (State or foreign country)

10. Usual occupation Furniture Salesman

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

Of autopsy \_\_\_\_\_

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

12. Name Henry Rice

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

14. Maiden name Addie Unknown

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

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) Accident

(b) Date of occurrence Nov. 19, 1944

(c) Where did injury occur? St. Louis Mo  
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place?  
Public Place

16. (a) Informant Olive Rice

(b) Address 4511 Forest Park

17. (a) Burial (b) Date thereof 11-25-44  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Lewistown Mo

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

(c) Means of injury an arrow

23. Signature Thomas F Callahan (M.D. or other)  
Address Deputy Coroner Date filed 11-24-44

18. (a) Signature of funeral director Albert H Hoppe

(b) Address 4700 Washington Ave

19. (a) NOV 24 1944 (b) [Signature]  
(Date received local registrar) (Registrar's signature)

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

MOTHER FATHER

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**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 *Albert G. Hoffer*  
.....  
.....Licensed Embalmer No. *2921*  
.....  
P. O. Address.....

**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.**