

U.S. No. 2
FORM-5-43
Rev. 5-17-39
I X36671

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH
1003

State File No. _____
Registrar's No. **610**

FILED JAN 31 1945
318
Registration District No. _____
Primary Registration District No. _____

1. PLACE OF DEATH:

(a) County _____
(b) City or town **St Louis**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
Homer C Phillips Hospital
(If not in hospital or institution, write street number or location) **0**
(d) Length of stay: In hospital or institution **3 days** (Specify whether
In this community **24 years** (Specify whether
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County _____
(c) City or town **St Louis**
(If outside city or town limits, write "RURAL") **25**
(d) Street No. **1720 O'Fallon**
(If rural, give location) **040**
(e) Citizen of foreign country? _____ (Yes or No) **17**
If yes, name country _____ **9**

3. (a) PRINT FULL NAME

Berths Rice

3. (b) If veteran, name war _____ No. _____
3. (c) Social Security No. _____

4. Sex **Female** 5. Color or race **Negro** 6. (a) Single, widowed, married, divorced **Married**
6. (b) Name of husband or wife **Zek Rice** 6. (c) Age of husband or wife if alive **58** years
7. Birth date of deceased **Apr 18 1892**
(Month) (Day) (Year)

8. AGE: Years **52** Months **9** Days **0** If less than one day _____ hr. _____ min.

9. Birthplace **Crossville Ind - 1**
(City, town, or county) (State or foreign county)
10. Usual occupation **Housewife**
11. Industry or business **None**
12. Name **John Taylor**
13. Birthplace **Ind - 1**
(City, town, or county) (State or foreign county)
14. Maiden name **Unavailable**
15. Birthplace **Ind - 1**
(City, town, or county) (State or foreign county)

MOTHER FATHER

16. (a) Informant **Zek Rice**
(b) Address **1720 O'Fallon**
17. (a) **Burial** (b) Date thereof **Jan 21 - 1945**
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation **Crossville Ind**
18. (a) Signature of funeral director **Jackson Funeral Home**
(b) Address **3649 Cheltenham**
19. (a) **JAN 21 1945** (b) **J. F. Bredeck**
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **January** day **18**
year **1945** hour **6** minute **35** AM.
21. I hereby certify that I attended the deceased from
January 15, 1945 to **January 18, 1945**
that I last saw her alive on **January 18, 1945**
and that death occurred on the date and hour stated above.

Immediate cause of death **Cerebral Hemorrhage**
Duration **Unknown**

Due to _____
Due to _____
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? _____
While at work? _____ (Specify type of place) (e) Means of injury **D**
23. Signature **Alva Moore** (M. D. or other) _____
Address **2501 N. Whittier St.** Date signed **1-18-45**

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

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 *James A. Johnson*
Licensed Embalmer No. 3522
P. O. Address 3506 Franklin

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.