

No. 2
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5-17-39
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FILED OCT 30 1945
Registration District No. 177

STANDARD CERTIFICATE OF DEATH

State File No. _____

Primary Registration District No. 3016

Registrar's No. 233

1. PLACE OF DEATH:

(a) County Cole

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

(c) Name of hospital or institution: St. Mary's Hospice
(If not in hospital or institution, write street number or location):

(d) Length of stay: In hospital or institution 2 Mo (Specify whether _____)

In this community _____
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Boone

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

(d) Street No. _____
(If rural, give location)

(e) Citizen of foreign country? No (Yes or No) _____
If yes, name country _____

MEDICAL CERTIFICATION

3. (a) PRINT FULL NAME James Howard Rice

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

20. DATE OF DEATH: Month OCT day 13
year 1945 hour 3 minute 15 P.M.

4. Sex Male 5. Color or race White

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

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

7. Birth date of deceased June 7 1945
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from Sept 10 1945 to Oct 13 1945
that I last saw him alive on Oct 11 1945
and that death occurred on the date and hour stated above.

8. AGE:	Years	Months	Days	If less than one day
		<u>4</u>	<u>6</u>	_____ hr. _____ min.

Immediate cause of death Tuberculous Disease
Secondary pneumonia

Due to _____

Duration 1 week

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

Due to _____

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

ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED

10. Usual occupation _____

11. Industry or business _____

Major findings: Of operations _____

PHYSICIAN

MOTHER FATHER

12. Name Howard Rice

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

14. Maiden name Hilda Estes

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

Of autopsy Male Calan
Chronic Spring Disease

Underline the cause to which death should be charged statistically.

16. (a) Informant Howard Rice

(b) Address Ashland Missouri

17. (a) Burial (b) Date thereof 10 17-45
(Burial, cremation, or removal) (Month) (Day) (Year)

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? _____

(c) Place: burial or cremation New Liberty Cem

18. (a) Signature of funeral director W. Q. Burnett

(b) Address Ashland Mo

19. (a) 10-13-45 (b) R. G. Darris MD
(Date received local registrar) (Registrar's signature)

(Specify type of place) _____

While at work? _____ (e) Means of injury _____

23. Signature R. G. Darris MD (M. D. or other) _____
Address Jefferson City Mo Date signed 10-15-45

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

RECEIVED

District Health Officer No. 9,

District File Number.....

Date Filed 10-29-45

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.....

Le Roy Claypool

Registered Apprentice No. 374

working under my personal supervision.

Signed *W. C. Bennett*

Licensed Embalmer No. 3564

P. O. Address *Ashtland 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

State File No. 23589

Registration District No. _____ Primary Registration District No. _____ Registrar's No. _____

1. PLACE OF DEATH:

(a) County _____
(b) City or town _____
(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 _____ years, months or days)

3. (a) PRINT FULL NAME

James H. Riel

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

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

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

7. Birth date of deceased _____ (Month) (Day) (Year)

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

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

10. Usual occupation _____

11. Industry or business _____

12. Name _____

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

14. Maiden name _____ (State or foreign country)

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

16. (a) Informant _____

(b) Address _____

17. (a) _____ (b) Date thereof _____ (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

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

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 _____ day _____ year _____ hour _____ minute _____ M.

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

By telephone: _____
Due to _____
Pneumonia, hypostatic
Due to _____
Fracture - spontaneous following transfusion
Major findings: _____
using bone marrow

Major findings: _____
Of operations _____
Of autopsy _____ *157 g 2*

22. If death was due to external causes, give 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 _____ (M. D. or other) _____
Address _____ Date signed _____

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

SUPPLEMENTARY

MOTHER FATHER

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

