

No. 2  
8-43  
17-39  
X37823

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **12416**  
Registrar's No. **126**

**FILED** APR 22 1946

Registration District No. **47** Primary Registration District No. **3008**

1. PLACE OF DEATH  
(a) County **CALLAWAY**  
(b) City or town **FULTON**  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: **826 Jefferson**  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether  
In this community **life** years, months or days)

2. USUAL RESIDENCE OF DECEASED:  
(a) State **Mo** (b) County **Callaway**  
(c) City or town **Fulton**  
(If outside city or town limits, write "RURAL")  
(d) Street No. **826 Jefferson**  
(If none, give location)  
(e) Citizen of foreign country? **No** (Yes or No)  
If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION

3. (a) PRINT FULL NAME **SAMUEL H. RICE**  
3. (b) If veteran, name war  3. (c) Social Security No. **✓**

20. DATE OF DEATH: Month **3** day **22**  
year **1946** hour **9** minute **P.M.**  
21. I hereby certify that I attended the deceased from **26** 19**46** to **Feb-3-22** 19**46**  
that I last saw him alive on **3-22-46** and that death occurred on the date and hour stated above.

4. Sex **MALE** 5. Color or race **White** 6. (a) Single, widowed, married, divorced **Widowed**  
6. (b) Name of husband or wife **Cordehia Fisher** 6. (c) Age of husband or wife if alive **DECEASED** years  
7. Birth date of deceased **Oct. 5 1850**  
(Month) (Day) (Year)

Immediate cause of death **Influenza + Asthmatic Heart** Duration **12 days**

8. AGE: Years **95** Months **5** Days **18** If less than one day hr. \_\_\_\_\_ min. \_\_\_\_\_

Due to \_\_\_\_\_  
Due to \_\_\_\_\_  
Other conditions **Nephritis + Cystitis**  
(Include pregnancy within 6 months of death)

9. Birthplace **CALLAWAY Co. MO**  
(City, town, or county) (State or foreign country)  
10. Usual occupation **Retired Farmer**

Major findings: Of operations \_\_\_\_\_  
Of autopsy \_\_\_\_\_  
**ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED**  
PHYSICIAN \_\_\_\_\_  
Underline the cause to which death should be charged statistically.

11. Industry or business \_\_\_\_\_  
12. Name **WILLIAM RICE**  
13. Birthplace **KY**  
(City, town, or county) (State or foreign country)  
14. Maiden name **SUSAN THOMAS**  
15. Birthplace **UNKNOWN**  
(City, town, or county) (State or foreign country)

16. (a) Informant **W. S. SUGGETT**  
(b) Address **FULTON, MO**  
17. (a) **BURIAL** (b) Date thereof **MAR. 24, 1946**  
(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 **ELMWOOD Mexico Mo**  
18. (a) Signature of funeral director **Glen Y. Manpin**  
(b) Address **712 Court St. Fulton, Mo.**  
19. (a) **3-23-1946** (b) **Joe Mosekoff**  
(Date received at local registrar) (Registrar's signature)

(Specify type of place)  
While at work? \_\_\_\_\_ (e) Means of injury \_\_\_\_\_  
23. Signature **W. O. Payne** (M. D. or other) \_\_\_\_\_  
Address **Rt 6 Fulton** Date signed **3-23-46**

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

RECEIVED

District Health Officer No. 9,

District File Number.....

Date Filed 4-19-66

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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 Glen G. Maupin

Licensed Embalmer No. 2725

P. O. Address Fulton, 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.**

Registration District No. 47

Primary Registration District No. 3008

1. PLACE OF DEATH:

(a) County Callaway  
(b) City or town Fulton  
(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 Samuel M. Rice

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 wid

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

7. Birth date of deceased Oct 5 (Month) (Day) (Year)

8. AGE: Years 95 Months 5 Days \_\_\_\_\_ If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

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

10. Usual occupation \_\_\_\_\_

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

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)

(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 \_\_\_\_\_ year 1946 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

Due to acute

Due to Influenza

Other conditions \_\_\_\_\_ (Include pregnancy within 3 months of death)

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

Of autopsy 33

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 W. O. ... (M. D. or other) \_\_\_\_\_ Date signed 4-26-46

Address R. B. Fuller

**SUPPLEMENTARY**

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



12416

