

20.2  
8-4  
5-17-39  
1 X37823

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS  
THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

13689

State File No. \_\_\_\_\_  
Registrar's No. \_\_\_\_\_

Registration District No. 1109 Primary Registration District No. 5614

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

1. PLACE OF DEATH:  
(a) County KNOX COUNTY  
(b) City or town Rura.  
(c) Name of hospital or institution: \_\_\_\_\_  
(If outside city or town limits, write "RURAL" and name of township)  
(d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether)  
In this community 82 yrs. years, months or days

3. (a) PRINT FULL NAME JAMES ROBERT 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 Widowed  
6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_ years  
7. Birth date of deceased Nov. 1 - 1862  
(Month) (Day) (Year)

8. AGE: Years 82 Months 11 Days 18 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

9. Birthplace KNOX Co. MISSOURI  
(City, town, or county) (State or foreign country)

10. Usual occupation Farmer.

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

12. Name Joseph Rice  
13. Birthplace Not known Virginia  
(City, town, or county) (State or foreign country)  
14. Maiden name Mary J. Musgrave  
15. Birthplace Not known Minnesota  
(City, town, or county) (State or foreign country)

16. (a) Informant J. C. Rice.  
(b) Address Leonard Mo.

17. (a) Funeral (b) Date thereof Oct 20/45  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Badaw Grove Cemetery

18. (a) Signature of funeral director W. Musgrave

(b) Address Bechel, Missouren

19. (a) \_\_\_\_\_ (b) W. S. Hunt  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:  
(a) State Missouri (b) County KNOX 52  
(c) City or town Rura. 3  
(If outside city or town limits, write "RURAL")  
(d) Street No. 2 1/2 mi South of Phenena.  
(If rural, give location)  
(e) Citizen of foreign country? 0 (Yes or No)  
If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month OCT day 19  
year 1945 hour 6 minute 5 A.M.

21. I hereby certify that I attended the deceased from Aug 19 1945 to Oct 17 1945  
that I last saw him alive on Oct 17 1945  
and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral Hemorrhage 2 Mo  
Duration  
Due to Arteriosclerosis ?

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

Major findings:  
Of operations \_\_\_\_\_  
Of autopsy gsw  
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? \_\_\_\_\_

(Specify type of place) \_\_\_\_\_  
(e) Means of injury 0  
While at work? \_\_\_\_\_

23. Signature Nels B. Jensen M.D. or other me  
Address Knox City Mo Date signed 10/21/45

RECEIVED

District Health Officer No. 10

District File Number 5-46-921

Date Filed MAY 14 1948

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.....

*[Signature]*....., Registered Apprentice No.....  
working under my personal supervision.

Signed *[Signature]*.....

Licensed Embalmer No. 2719

P. O. Address Bethel 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. X69

Primary Registration District No. 5614

1. PLACE OF DEATH:

(a) County Knox  
(b) City or town Rural near ~~town~~  
(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 \_\_\_\_\_  
In this community \_\_\_\_\_  
years, months or days) (Specify whether)

3. (a) PRINT FULL NAME James R. 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 \_\_\_\_\_

7. Birth date of deceased mo. 1  
(Month) (Day) (Year)

8. AGE: Years 82 Months 11 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 Farmer

12. Name Joseph Rice

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

14. Maiden name Mary Jennings

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

16. (a) Informant J. C. Rice  
(b) Address Leonard, mo

17. (a) (Burial, cremation, or removal) \_\_\_\_\_ (b) Date thereof 10-20-51  
(Month) (Day) (Year)  
(c) Place: burial or cremation Cedar Grove Cemetery

18. (a) Signature of funeral director E. W. Musgrave  
(b) Address Bethel, mo

19. (a) \_\_\_\_\_ (b) Neil S. Nordt  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State MO (b) County Knox  
(c) City or town Plevana  
(If outside city or town limits, write "RURAL")  
(d) Street No. 2 1/2 mi South Road  
(If rural, give location)  
(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct 1951  
year \_\_\_\_\_ floor \_\_\_\_\_ minute \_\_\_\_\_ M.

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

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 \_\_\_\_\_

23. Signature \_\_\_\_\_ (M. D. or other) \_\_\_\_\_  
Address \_\_\_\_\_ Date signed \_\_\_\_\_

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

SUPPLEMENTARY

13689