

No. 2
-5-43
-5-17-39
X3667

FILED AUG 12 1946

State File No. _____

Registration District No. 146

Primary Registration District No. 5568

Registrar's No. 246

1. PLACE OF DEATH:

(a) County Jackson
(b) City or town Kansas City, Mo. (Rural) Blue
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
7700 East 40 Hiway
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____
In this community 21 Years
years, months or days (Specify whether)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson
(c) City or town Kansas City (Rural)
(If outside city or town limits, write "RURAL")
(d) Street No. 35 th & Blue Ridge
(If rural, give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME Douglas Joseph Rice

3. (b) If veteran, name war World War Two 3. (c) Social Security No. 491-20-1937

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 Oct 2 1924
(Month) (Day) (Year)

8. AGE: Years 21 Months 9 Days 2 If less than one day _____ hr. _____ min.

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

10. Usual occupation _____

11. Industry or business _____

12. Name William H. Rice

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

14. Maiden name Laura Bellisle

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

16. (a) Informant William H. Rice

(b) Address 3050 Harrison, K.C. Mo.

17. (a) Burial (b) Date thereof 7/6/46
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Brooking Cem.

18. (a) Signature of funeral director Geo. C. Carson

(b) Address Independence, Missouri

19. (a) 7-15-1946 (b) _____
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 7 day 4
year 1946 hour 4:00 minute a M.

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____;
Carson
that I last saw h_____ alive on _____, 19____;
and that death occurred on the date and hour stated above.

Immediate cause of death _____
Skull Fracture
Due to Auto Trauma

Due to _____
Other conditions _____
(Include pregnancy within 3 months of death)
Major findings:
Of operations _____

Of autopsy no
Hickey & Jumper
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) accident
(b) Date of occurrence 7-4-46
(c) Where did injury occur? Public place
(City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place?

While at work? no (Specify type of place) (e) Means of injury Auto

23. Signature James Bellisle (M. D. or other)
Address 1424 My My Date signed 7-4-46

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

MOTHER FATHER

AUG 10 1946

OCT 23 1946

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 Raymond N. Martin.....

Licensed Embalmer No. 4158.....

P. O. Address Indy, Ind......

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.

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUSTHE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATHState File No. AugRegistration District No. 146Primary Registration District No. 5568Registrar's No. 2418

1. PLACE OF DEATH:

(a) County Jackson
(b) City or town Rural
(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 days3. (a) PRINT FULL NAME Douglas J. Reil

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 5

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

7. Birth date of deceased Oct 2
(Month) (Day) (Year)8. AGE: Years 21 Months _____ 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 _____
(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 (month) _____ (day) _____ (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 _____

Duration _____

Skull FractureDue to **Auto Trauma**Due to Lost Control of his carOther 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) **Accident**(b) Date of occurrence **7-4-46**(c) Where did injury occur? **Jackson Co Mo**
(City or town) (County) (State)(d) Did injury occur in or about home, on farm, in industrial place, in public place?
Public Place - Public HighwayWhile at work? **no** (Specify type of place) **Auto**
(e) Means of injury _____23. Signature **James C. Walker, Coroner** (M. D. or other) _____Address **1424 Professional Bldg** Date signed **7-4-46**

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

22603

23948

The deceased was found lying beside his car a 1935 four door sedan, deceased apparently lost control of car. car had skidded about 100 feet and then turned over about two times, causing head injuries and death.

This was the report of the Investigator turned in.

OCT 23 1946 40