

FILED OCT 26 1948

Registration District No. **76**

Primary Registration District No. **5347**

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

1. PLACE OF DEATH:

(a) County **Dallas**
(b) City or town **Rural N. Benton**
(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 **3 months**
years, months or days

3: (a) PRINT FULL NAME **Francis T. 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 **M**

6: (b) Name of husband or wife **Sarah Rice** 6: (c) Age of husband or wife if alive **60** years

7. Birth date of deceased **Aug 14 1888**
(Month) (Day) (Year)

8. AGE: Years **70** Months **1** Days **19** If less than one day _____ hr. _____ min.

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

10. Usual occupation **Farmer**

11. Industry or business _____

12. Name **W. J. Rice**

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

14. Maiden name **ATTN Papp**

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

16: (a) Informant **Sarah Rice**

(b) Address **Buffalo Mo.**

17: (a) **Burial** (Burial, cremation, or removal) (b) Date thereof **10-6-1948**
(Month) (Day) (Year)

(c) Place: burial or cremation **Forest Hill H.C. Mo**

18: (a) Signature of funeral director **Montgomery Vaughan**

(b) Address **Buffalo Mo.**

19: (a) **10-23-48** (Date received local registrar) (b) **Mrs. J. B. Lane** (Registrar's signature) **78**

2. USUAL RESIDENCE OF DECEASED:

(a) State **Mo** (b) County **Dallas**

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

(d) Street No. **Buffalo Mo.** (If rural, give location)

(e) Citizen of foreign country? **No** (Yes or No)

If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **10** day **3**
year **1948** hour **4** minute **30 P. M.**

21. I hereby certify that I attended the deceased from **July 1 1948** to **10-3 1948**
that I last saw him alive on **Sept 25 1948**
and that death occurred on the date and hour stated above.

Immediate cause of death **Carcinoma of prostate gland** **DK**

Due to **DK**

Due to **Anemia** **DK**

Other conditions **Anemia** **DK**
(Include pregnancy within 3 months of death)

Major findings: **Carcinoma of prostate gland** **DK**
Of operations _____
Of autopsy **None**

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 **G. P. Summers M.D.** M. D. or other **MD**
Address **Buffalo Mo** Date signed **10-5-48**

RECEIVED

District Health Officer No. 7;

District File Number 9-48-1243

Date Filed 10-25-48

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. 10
working under my personal supervision.

Signed Blyde Montgomery

Licensed Embalmer No. 3592

P. O. Address Buffalo, Md.

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.