

FILED MAR 22 1949

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

8585

State File No. ....

|  |  |  |   |  |  |   |  |
|--|--|--|---|--|--|---|--|
| BIRTH NO. _____  |  | REG. DIST. NO. <u>149</u>  |   | PRIMARY REG. DIST. NO. <u>1002</u>   |  | Registrar's No. <u>797</u>  |  |
| 1. PLACE OF DEATH<br>a. COUNTY <u>Jackson</u>  |  |  |   | 2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).<br>a. STATE <u>Mo</u> b. COUNTY <u>Clay</u> <u>24</u> |  |   |  |
| b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Kansas City</u>  |  | c. LENGTH OF STAY (In this place) <u>56 yrs</u>  |   | c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Rural</u>  |  | 9   |  |
| d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Memorial Hospital</u>   |  |  |   | d. STREET ADDRESS (If rural, give location) <u>RR. 488 North Kansas City</u>   |  |   |  |
| 3. NAME OF DECEASED (Type or Print)<br>a. (First) <u>Charles</u> b. (Middle) <u>Francis</u> c. (Last) <u>Rice</u>  |  |  | 4. DATE OF DEATH (Month) (Day) (Year) <u>2-18-49</u>  |  |  |   |  |
| 5. SEX <u>Male</u>   |  | 6. COLOR OR RACE <u>White</u>  |   | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Widowed</u>  |  | 8. DATE OF BIRTH <u>May 23, 1866</u>  |  |
| 9. AGE (In years last birthday) <u>82</u>  |  | IF UNDER 1 YEAR Months Days Hours Min. <u>- - - -</u>  |   | IF UNDER 24 HRS. Hours Min. <u>- -</u>   |  |   |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Restaurant/Hotel operator</u>   |  | 10b. KIND OF BUSINESS OR INDUSTRY <u>Hotel &amp; Restaurant</u>  |   | 11. BIRTHPLACE (State or foreign country) <u>Kentucky</u>  |  | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u>   |  |
| 13a. FATHER'S NAME <u>John William Rice</u>  |  |  | 13b. MOTHER'S MAIDEN NAME <u>Marion Francis Green</u> |  |  | 14. NAME OF HUSBAND OR WIFE <u>Martha Rice</u>                                      |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>   |  | 16. SOCIAL SECURITY NO. <u>None</u>  |   | 17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>Mrs Etta Luvene Hydeman RR 488 No K.C.</u>  |  |   |  |
| 18. CAUSE OF DEATH<br>Enter only one cause per line for (a), (b), and (c)<br><br>*This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.                                  |  | MEDICAL CERTIFICATION<br>I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Bronchiectasis</u><br><u>Cardiac Decompensation</u><br>ANTECEDENT CAUSES<br>Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.<br>DUE TO (b) <u>Chronic Bronchitis</u><br>DUE TO (c) <u>—</u><br>II. OTHER SIGNIFICANT CONDITIONS<br>Conditions contributing to the death but not related to the disease or condition causing death. <u>502</u> |   |  |  | INTERVAL BETWEEN ONSET AND DEATH<br><u>7 days</u><br><u>5 years</u>                 |  |
| 19a. DATE OF OPERATION _____   |  | 19b. MAJOR FINDINGS OF OPERATION _____   |   |  |  | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 21a. ACCIDENT SUICIDE HOMICIDE (Specify) <u>no</u>   |  | 21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) _____   |   | 21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) _____  |  |   |  |
| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) _____  |  | 21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |   | 21f. HOW DID INJURY OCCUR? _____   |  |   |  |
| 22. I hereby certify that I attended the deceased from <u>Feb 17, 1949</u> , to <u>Feb 18, 1949</u> , that I last saw the deceased alive on <u>Feb 18, 1949</u> , and that death occurred at <u>11:35 a.m.</u> , from the causes and on the date stated above. |  |  |   |  |  |   |  |
| 23a. SIGNATURE <u>Joseph Gefelson</u> (Degree or title) <u>D. M. D.</u>  |  |  |   | 23b. ADDRESS <u>1219 Realto Bldg.</u>  |  | 23c. DATE SIGNED <u>2-20-49</u>   |  |
| 24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>   |  | 24b. DATE <u>Feb. 20-49</u>  |   | 24c. NAME OF CEMETERY OR CREMATORY <u>Greenwood</u>  |  | 24d. LOCATION (City, town, or county) (State) <u>Macon Mo.</u>                      |  |
| DATE REC'D BY LOCAL REG. <u>2-20-49</u>  |  | REGISTRAR'S SIGNATURE <u>Sheraldine Holmes</u>   |   | 25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Morton-Smiths Funeral Home No K.C.</u>   |  |   |  |

(Licensed Embalmer's Statement on Reverse Side)

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

**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.....

..... Student Embalmer No. ....

working under my personal supervision.

Student .....  
Student Embalmer

Signed *Thomas O Smith*.....

Licensed Embalmer No. *3928*

P. O. Address *North Kansas City*

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.