

FILED MAY 19 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **14840**

BIRTH NO. _____ REG. DIST. NO. **38** PRIMARY REG. DIST. NO. **3006** Registrar's No. **122**

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

1. PLACE OF DEATH a. COUNTY Boone		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY Boone	
b. CITY (If outside corporate limits, write RURAL and give township) Columbia		c. CITY (If outside corporate limits, write RURAL and give township) Columbia	
c. LENGTH OF STAY (If in this place) Life		d. STREET ADDRESS (If rural, give location) 410 Jackson St	
d. FULL NAME OF HOSPITAL OR INSTITUTION Boone Co Hospl			
3. NAME OF DECEASED (Type or Print) a. (First) Stanton b. (Middle) Humes c. (Last) Rice			4. DATE OF DEATH (Month) (Day) (Year) May 7 1949
5. SEX M	6. COLOR OR RACE W	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) m	8. DATE OF BIRTH Aug 8th 1896
9. AGE (In years - last birthday) 52		IF UNDER 1 YEAR: Days 8 Hours 39	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter		10b. KIND OF BUSINESS OR INDUSTRY Building	11. BIRTHPLACE (State or foreign country) Boone Co. MO
12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13a. FATHER'S NAME Wallace Rice		13b. MOTHER'S MAIDEN NAME Gussie Mae	14. NAME OF HUSBAND OR WIFE Mattie E Rice
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no	16. SOCIAL SECURITY NO. (If yes, give war or dates of service) no	17. INFORMANT'S SIGNATURE OR NAME Mattie E Rice ADDRESS 410 Jackson	
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asphyxia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) intestinal abs. Gall Stone INTERVAL BETWEEN ONSET AND DEATH 6 days ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) cholecystitis & cholelithiasis DUE TO (c) II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. 585X	
19a. DATE OF OPERATION May 7-49	19b. MAJOR FINDINGS OF OPERATION intestinal abs - Gall Stone Intestinal perforation & early peritonitis		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21a. ACCIDENT SUICIDE HOMICIDE (Specify)	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) m.	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 May 6, 1949 to May 7, 1949 that I last saw the deceased alive on May 7, 1949 and that death occurred at 5:15 p.m. , from the causes and on the date stated above.			
23. SIGNATURE (Degree or title) Edwina Schmitt MD		23b. ADDRESS Columbia, MO	23c. DATE SIGNED 5-9-49
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE May 12 1949	24c. NAME OF CEMETERY OR CREMATORY New Providence	24d. LOCATION (City, town, or county) (State) Boone Co MO
DATE REC'D BY LOCAL REG. May 11 1949	REGISTRAR'S SIGNATURE Mrs R E Palmox	25. FUNERAL DIRECTOR'S SIGNATURE J. C. ... ADDRESS	

RECEIVED
District Health Officer No. 9,
District File Number
Date Filed
MAY 18 1949

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, ~~me~~

Student Embalmer No.

working under my personal supervision.

Student
Student Embalmer

Signed

Lyman H. Spunkle

Licensed Embalmer No. 4013

P. O. Address Columbia, 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.