

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

FILED JUN 20 1949

State File No. 18963

BIRTH NO. _____ REG. DIST. NO. 75 PRIMARY REG. DIST. NO. 3015 Registrar's No. 34

1. PLACE OF DEATH a. COUNTY CLINTON		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE MO. b. COUNTY CLINTON	
b. CITY (If outside corporate limits, write RURAL and give township) CAMERON		c. CITY (If outside corporate limits, write RURAL and give township) CAMERON MO.	
c. LENGTH OF STAY (in this place) life		d. STREET ADDRESS (If rural, give location) 918 West 4th	
d. FULL NAME OF HOSPITAL OR INSTITUTION 918 West 4th			

3. NAME OF DECEASED (Type or Print)	a. (First) James	b. (Middle) RAYMOND	c. (Last) Rice	4. DATE OF DEATH (Month) (Day) (Year)
				June 2 1949

5. SEX M	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) never married	8. DATE OF BIRTH June 19-1890	9. AGE (In years last birthday) 58	IF UNDER 1 YEAR Months Days	IF UNDER 1 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RAILROAD	10b. KIND OF BUSINESS OR INDUSTRY RAILROAD	11. BIRTHPLACE (State or foreign country) Missouri	12. CITIZEN OF WHAT COUNTRY? USA.			

13a. FATHER'S NAME John Rice	13b. MOTHER'S MAIDEN NAME MARY KENNEY	14. NAME OF HUSBAND OR WIFE NONE
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) yes Work War I	16. SOCIAL SECURITY NO. 491-22-6370	17. INFORMANT'S SIGNATURE OR NAME Maurice K. Rice	ADDRESS Cameron Mo.
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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, asthma, etc. It means the disease, injury, or complication which caused death.	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Disease of the Coronary Arteries (Coronary Occlusion)		INTERVAL BETWEEN ONSET AND DEATH Immediate
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____		
	II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		4301

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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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 <input type="checkbox"/> WORK NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at **11:15 P. m.**, from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) R. P. Tompkins, Coroner, Clinton Co.	23b. ADDRESS Cameron Mo.	23c. DATE SIGNED 6-3-49
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24a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	24b. DATE 6-4-49	24c. NAME OF CEMETERY OR CREMATORY Kenney Cemetery	24d. LOCATION (City, town, or county) (State) Kider MO
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DATE REC'D BY LOCAL REG. 6-6-49	REGISTRAR'S SIGNATURE Winifred W. Moser	25. FUNERAL DIRECTOR'S SIGNATURE Poland Funeral Home	ADDRESS Cameron Mo.
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

JUN 7 1949

JUL 8 1949

JUL 7

JUN 22 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, or by _____

Student Embalmer No. 318

working under my personal supervision.

Signed Robert H. Poland
Student Embalmer

Signed George P. Hammett
Licensed Embalmer No. 4425

P. O. Address 224 West 3rd

Camden, 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.