

FILED JUN 17 1950

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 21943
5121

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

BIRTH NO. _____		REG. DIST. NO. <u>318</u>		PRIMARY REG. DIST. NO. <u>1003</u>		Registrar's No. _____	
1. PLACE OF DEATH a. COUNTY _____				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE _____ b. COUNTY _____			
b. CITY (If outside corporate limits, write RURAL and give township) <u>St. Louis</u>		c. LENGTH OF STAY (in this place) <u>17 days</u>		c. CITY (If outside corporate limits, write RURAL and give township) <u>St. Louis, Mo 2229</u>		d. STREET ADDRESS (If rural, give location) <u>1137 Dillon Drive</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>St Louis Childrens Hospital</u>							
3. NAME OF DECEASED (Type or Print) a. (First) <u>Betty</u>		b. (Middle) <u>Jean</u>		c. (Last) <u>Rice</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>6 10 50</u>	
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>n</u>		8. DATE OF BIRTH <u>11-16-45</u>	
9. AGE (In years last birthday) <u>4 yrs</u>		IF UNDER 1 YEAR Months _____ Days _____		IF UNDER 1 YEAR Months _____ Days _____		IF UNDER 1 YEAR Hours _____ Min. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Infant</u>		10b. KIND OF BUSINESS OR INDUSTRY _____		11. BIRTHPLACE (State or foreign country) <u>St Louis, Mo</u>		12. CITIZEN OF WHAT COUNTRY? _____	
13a. FATHER'S NAME <u>Lavell Rice</u>		13b. MOTHER'S MAIDEN NAME <u>Juanita Osin</u>		14. NAME OF HUSBAND OR WIFE _____			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) _____		16. SOCIAL SECURITY NO. _____		17. INFORMANT'S SIGNATURE OR NAME <u>Lavell Rice 1137 Dillon Drive</u>			
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.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Lymphoid Leukemia</u> ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____				INTERVAL BETWEEN ONSET AND DEATH _____	
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.							
19a. DATE OF OPERATION _____		19b. MAJOR FINDINGS OF OPERATION _____				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) <u>204.0</u>			
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? <u>204.0</u>			
22. I hereby certify that I attended the deceased from <u>5-24</u> , 1950, to <u>6-10</u> , 1950, that I last saw the deceased alive on <u>6-10</u> , 1950, and that death occurred at <u>2:55 Am.</u> , from the causes and on the date stated above.							
23a. SIGNATURE <u>Wm G Klingberg M.D.</u>				23b. ADDRESS <u>2145 Princeton</u>		23c. DATE SIGNED <u>6-10-50</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		24b. DATE <u>6-12-50</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Mount Hope</u>		24d. LOCATION (City, town, or county) (State) <u>St. Louis County MO</u>	
DATE REC'D BY LOCAL <u>JUN 12 1950</u>		REGISTRAR'S SIGNATURE <u>J B Farster</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>McLaughlin Funl Hm. 2301 Lafayette</u>			

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.....

.....
working under my personal supervision.

Student Embalmer No.....

Signed.....
Student Embalmer

Signed *James R. Chapman*

Licensed Embalmer No. *4550*

P. O. Address *White Plains, N.Y.*

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.