

FILED SEP 5 1950

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 28591
2341

BIRTH NO. _____ REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003 Registrar's No. _____

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis		a. STATE Missouri b. COUNTY	
c. LENGTH OF STAY (in this place)		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis	
d. FULL NAME OF HOSPITAL OR INSTITUTION 2617 Indiana		d. STREET ADDRESS (If rural, give location) 23 2617 Indiana	

3. NAME OF DECEASED (Type or Print)	a. (First) Dr. George	b. (Middle) H.	c. (Last) Rice	4. DATE OF DEATH (Month) (Day) (Year)
				8/26/50

5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH Dec. 16, 1855	9. AGE (In years last birthday) 94	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Hours	IF UNDER 15 MIN. Mins.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Physician	10b. KIND OF BUSINESS OR INDUSTRY ----	11. BIRTHPLACE (State or foreign country) St. Charles, Missouri	12. CITIZEN OF WHAT COUNTRY? USA
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13a. FATHER'S NAME Caleb Rice	13b. MOTHER'S MAIDEN NAME Nancy Bacon	14. NAME OF HUSBAND OR WIFE Blanche
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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) No	16. SOCIAL SECURITY NO. ---	17. INFORMANT'S SIGNATURE OR NAME Blanche Rice--2617 Indiana	ADDRESS
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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, asthenia, etc. It means the disease, injury, or complication which caused death.	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <i>Senility Arterio-Sclerosis</i>		INTERVAL BETWEEN ONSET AND DEATH
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <i>Adopted eye</i>		
	DUE TO (c)		
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"/>
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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)
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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? <i>45 ft</i>
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22. I hereby certify that I attended the deceased from *Jan. 24*, 1950, to *Aug 26*, 1950, that I last saw the deceased alive on *Aug 25*, 1950, and that death occurred at *3:40 p* m., from the causes and on the date stated above.

22a. SIGNATURE <i>W. D. Morganford</i>	(Degree of title) <i>M. D.</i>	22b. ADDRESS <i>4717 Morganford Rd.</i>	22c. DATE SIGNED <i>8/28/50</i>
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24a. BURIAL, CREMATION, REMOVAL (Specify) Cremation	24b. DATE <i>8/29/50</i>	24c. NAME OF CEMETERY OR CREMATORY Valhalla Crematory	24d. LOCATION (City, town, or county) (State) St. Louis Co., Missouri
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DATE REC'D BY LOCAL REG. <i>AUG 29 1950</i>	REGISTRAR'S SIGNATURE <i>J. B. Lavater</i>	25. FUNERAL DIRECTOR'S SIGNATURE <i>Wacker-Heldule</i>	ADDRESS <i>3634 Gravois</i>
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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.....

.....
working under my personal supervision.

Student Embalmer No.....

Signed Robert C. Wheeler

Signed.....
Student Embalmer

Licensed Embalmer No. 2128

P. O. Address St. Louis, 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.