

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

27724

State File No.

SEP 14 1953

BIRTH NO. _____ REG. DIST. NO. 38 PRIMARY REG. DIST. NO. 3006 Registrar's No. 241

1. PLACE OF DEATH a. COUNTY <u>Boone</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY <u>Boone</u>	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Columbia</u>		c. CITY OR TOWN <u>Columbia</u>	d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Boone County Hospital</u>		e. STREET ADDRESS (If rural, give location) <u>814 Sandifer St. 0105</u>	

3. NAME OF DECEASED (Type or Print)	a. (First) <u>SAMUEL</u>	b. (Middle) <u>MONROE</u>	c. (Last) <u>RICE</u>	4. DATE OF DEATH (Month) (Day) (Year) <u>Sept. 7, 1953</u>
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5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>	8. DATE OF BIRTH <u>Aug. 16, 1896</u>	9. AGE (In years last birthday) <u>57</u>	IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u>	IF UNDER 24 HRS. Hours <u>0</u> Min. <u>0</u>
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Electrician</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>City of Columbia</u>	11. BIRTHPLACE (City and State or Foreign Country) <u>Boone County Mo.</u>	12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
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13a. FATHER'S NAME <u>David D. Rice</u>	13b. MOTHER'S MAIDEN NAME <u>Elizabeth Fox</u>	14. NAME OF Deceased's WIFE <u>Irene Rice</u>
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>	16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <u>486-12-2639</u>	17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>Irene Rice, Columbia, Mo.</u>
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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, asphyxia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH <u>7 days</u>
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Cerebral Hemorrhage</u>		
	ANTECEDENT CAUSES Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Hypertensive Vascular Disease</u> 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) <u>3312</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? _____

22. I hereby certify that I attended the deceased from Sept 3, 1953, to Sept 7, 1953 that I last saw the deceased alive on Sept 6, 1953 and that death occurred at 5:45 a.m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) <u>Charles W. Lauke, M.D.</u>	23b. ADDRESS <u>Columbia, Missouri</u>	23c. DATE SIGNED <u>9-8-53</u>
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24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	24b. DATE <u>9-9-1953</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Memorial Park</u>	24d. LOCATION (City, town, or county) (State) <u>Columbia, Mo.</u>
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DATE REC'D BY LOCAL REG. <u>Sept 8 1953</u>	REGISTRAR'S SIGNATURE <u>Mrs R.E. Palmer</u>	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>MEMORIAL FUNERAL HOME? COLUMBIA? MO.</u>
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LWS

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

251755

21 1953
JAN 8

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, ~~and~~, Student Embalmer No. working under my personal supervision..

Student.....
Signature of Student Embalmer

Signed *Lynman H. Sprinkle*

Licensed Embalmer No. *4013*

P. O. Address *Columbia*

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.