

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **45519**

FILED JAN 19 1954 REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003** Registrar's No. **12110**

1. PLACE OF DEATH a. COUNTY 0		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Missouri b. COUNTY	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis	
d. FULL NAME OF HOSPITAL OR INSTITUTION Homer G. Phillips Hospital		d. STREET ADDRESS (If rural, give location) 5338 Bulwer Street	

3. NAME OF DECEASED (Type or Print) Robert Rice			4. DATE OF DEATH (Month) (Day) (Year) Dec. 19, 1953		
a. (First)		b. (Middle)		c. (Last)	

5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) married	8. DATE OF BIRTH Nov. 16, 1893	9. AGE (In years last birthday) 60	IF UNDER 1 YEAR Months 1 Days 3	IF UNDER 12 HRS. Hours 0 Mins.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Custodian	10b. KIND OF BUSINESS OR INDUSTRY City Hall	11. BIRTHPLACE (City and State or Foreign Country) Mariana, Arkansas	12. CITIZEN OF WHAT COUNTRY? U. S. A.
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13a. FATHER'S NAME Berle Rice	13b. MOTHER'S MAIDEN NAME Laura Hill	14. NAME OF HUSBAND OR WIFE Lena Rice
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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 Lena Rice	ADDRESS 5338 Bulwer Street
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18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) <i>*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>	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Ruptured of Dissecting Aneurysm of the Aorta		
	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 checked="" type="checkbox"/> NO <input 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? 451X
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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 5:06 Am., from the causes and on the date stated above.

23a. SIGNATURE Charles J. Taylor, Coronar	23b. ADDRESS 1300 Clarke Avenue	23c. DATE SIGNED 12.23.53
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24a. BURIAL, CREMATION, REMOVAL (Specify) Removal	24b. DATE 12/24/53	24c. NAME OF CEMETERY OR CREMATORY Greenwood Cemetery	24d. LOCATION (City, town, or county) (State) St. Louis County, Missouri
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DATE REC'D BY LOCAL REG. DEC 23 1953	REGISTRAR'S SIGNATURE Earl Smith, M.D.	25. FUNERAL DIRECTOR'S SIGNATURE Charles J. Gates	ADDRESS 4107 Finney Ave.
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(Licensed Embalmer's Statement on Reverse Side)

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 _____

Student Embalmer No. _____

working under my personal supervision.

Student
Student Embalmer

Signed Arthur L. Hilliard

Licensed Embalmer No. 4221

P. O. Address. 4107 Finney Avenue

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.