

STATE OF MISSOURI
CERTIFICATE OF DEATH

State File No. 2012
3149

FILED AUG 10 1954

BIRTH NO. _____ REG. DIST. NO. 149 PRIMARY REG. DIST. NO. 1002 Registrar's No. _____

1. PLACE OF DEATH a. COUNTY Jackson		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY Jackson	
b. CITY (If outside corporate limits, write RURAL and give township) Town Kansas City		c. CITY OR TOWN Kansas City	
d. FULL NAME OF HOSPITAL OR INSTITUTION. 2025 Kansas		e. STREET ADDRESS (If rural, give location) 23 2025 Kansas	

3. NAME OF DECEASED (Type or Print) William Rice			4. DATE OF DEATH (Month) (Day) (Year) July 2, 1954		
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5. SEX Male	6. COLOR OR RACE Colored	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH Dec. 18, 1867	9. AGE (In years last birthday) 86	10. UNDER 1 YEAR Months _____ Days _____	11. UNDER 24 HRS. Hours _____ Min. _____
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and State or Foreign Country) Arkansas	12. CITIZEN OF WHAT COUNTRY? USA
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13a. FATHER'S NAME Unknown	13b. MOTHER'S MAIDEN NAME Unknown	14. NAME OF HUSBAND OR WIFE Lucenda 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. No	17. INFORMANT'S SIGNATURE OR NAME Lucenda Rice	ADDRESS 2025 Kansas
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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, asphyxia, 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) Coronary Occlusion		
	ANTECEDENT CAUSES DUE TO (b) Generalized Arteriosclerosis <i>Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.</i>		
DUE TO (c)			
II. OTHER SIGNIFICANT CONDITIONS <i>Conditions contributing to the death but not related to the disease or condition causing death.</i>			

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) (m.)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?
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22. I hereby certify that I attended the deceased from **June 1, 1954** to **July 2, 1954**, that I last saw the deceased alive on **June 30, 1954**, and that death occurred at **11:40 a.m.**, from the causes and on the date stated above.

23a. SIGNATURE Bruce P. McDonald (Degree or title) of MD	23b. ADDRESS 2604 Prospect Avenue	23c. DATE SIGNED 7/2/54
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24a. BURIAL, CREMATION, REMOVAL (Specify) Removal	24b. DATE 7/8/54	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State) Idabel, Oklahoma
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DATE REC'D BY LOCAL REG. 7-7-54	REGISTRAR'S SIGNATURE Sheraldine Smith	25. FUNERAL DIRECTOR'S SIGNATURE Watkins Bros. 18th & Beaton	ADDRESS
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(Licensed Embalmer's Statement on Reverse Side)

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

Dr
McDonald

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.....
Signature of Student Embalmer

Signed.....
Bruce L. Watkins

Licensed Embalmer No. 450

P. O. Address 18th & Len

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.