

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No.

7387

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). a. STATE <u>Illinois</u> b. COUNTY <u>Perry</u>			
b. CITY (If outside corporate limits, write RURAL and give OR TOWN <u>St. Louis</u>)		c. LENGTH OF STAY (In this place) _____		c. CITY OR TOWN <u>Pinckneyville</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Deaconess Hospital</u>		e. STREET ADDRESS (If rural, give location) <u>RFD 2</u>		d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or Print) a. (First) <u>Homer</u> b. (Middle) <u>O.</u> c. (Last) <u>Rice</u>			4. DATE OF DEATH (Month) (Day) (Year) <u>Aug. 19, 1955</u>		
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, 1917</u>	9. AGE (In years last birthday) <u>38</u>	IF UNDER 1 YEAR Months _____ Days _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Miner</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Coal</u>	11. BIRTHPLACE (City and State or Foreign Country) <u>Perry Co., Ill.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>
13a. FATHER'S NAME <u>Harry Rice</u>		13b. MOTHER'S MAIDEN NAME <u>Sabrie Koenezstein</u>		14. NAME OF HUSBAND OR WIFE <u>Lola Pearl Rice</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> (If yes, give year or dates of service) <u>WW II</u>		16. SOCIAL SECURITY NO. <u>Unknown</u>	17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>Lola Pearl Rice, Pinckneyville, Ill.</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>Carcinoma Esophagus</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) _____ II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>Wolff Parksyndrom - not controlled - caused demise</u>				INTERVAL BETWEEN ONSET AND DEATH _____
19a. DATE OF OPERATION _____	19b. MAJOR FINDINGS OF OPERATION <u>Carcinoma of Esophagus -</u>			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) <u>150 X</u>	(STATE) _____	
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 <u>8/17</u> , 19 <u>55</u> , to <u>8/20</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>8/20, 1955</u> , and that death occurred at <u>9:35p</u> m., from the causes and on the date stated above.					
23a. SIGNATURE (Type or Print) <u>Jose L Lucido MD</u>			23b. ADDRESS <u>634 N. Grand</u>		23c. DATE SIGNED <u>8/22</u>
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	24b. DATE <u>8-19-55</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Sunset Memorial</u>	24d. LOCATION (City, town, or county) (State) <u>Perry Co., Ill.</u>		
DATE REC'D BY LOCAL REG. <u>AUG 23 1955</u>	REGISTRAR'S SIGNATURE <u>J. Carl Smith MD</u>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Albert H. Hoppe, 4700 Washington Blvd.</u>		

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
Signature of Student Embalmer

Signed

John J. Steiner

Licensed Embalmer No. 410

P. O. Address *St. Paul*

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.