

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

12709

STATE FILE NUMBER

APR 16 1957

Registration District No. 113

Primary Registration District No. 4185

Registrar's No. 606

1. PLACE OF DEATH a. COUNTY <i>Franklin</i>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Mo</i> b. COUNTY <i>Franklin</i>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <i>St. Clair</i>		c. CITY OR TOWN <i>St. Clair</i>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <i>St. Clair Lifetime</i>		d. STREET ADDRESS (If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>First Daniel Middle Robert Last Rice</i>		4. DATE OF DEATH <i>3-25-1957</i>	
5. SEX <i>M</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>3-6-1956</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>✓</i>		11. BIRTHPLACE (City and state or country) <i>Washington Mo</i>	
10b. KIND OF BUSINESS OR INDUSTRY <i>✓</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S. &</i>	
13. FATHER'S NAME <i>Thomas H Rice</i>		14. MOTHER'S MAIDEN NAME <i>Annie Jones</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <i>✓</i>		16. SOCIAL SECURITY NO. <i>✓</i>	
17. INFORMANT <i>Thomas H Rice</i>		Address <i>St. Clair, Mo.</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE <i>Secondary Bronchopneumonia</i> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <i>Acute Bronchitis Asthmal</i> DUE TO (c) <i>4 days</i>			INTERVAL BETWEEN ONSET AND DEATH <i>3 days</i>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour Month, Day, Year a. m. p. m.			
20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	
		20f. CITY, TOWN, OR LOCATION <i>St. Clair</i> COUNTY STATE	
21. I attended the deceased from <i>3-18-57</i> to <i>3-25-57</i> and last saw <i>him</i> alive on <i>3-24-</i> Death occurred at <i>3-6-</i> m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <i>Dr. W. E. Kitchell - M.D.</i>		22b. ADDRESS <i>St. Clair Mo</i>	
		22c. DATE SIGNED <i>3/25-</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE <i>3-26-57</i>	
23c. NAME OF CEMETERY OR CREMATORY <i>Odd Fellows</i>		23d. LOCATION (City, town, or county) (State) <i>St. Clair Mo</i>	
24. FUNERAL DIRECTOR ADDRESS <i>Sheldon W Kitchell St. Clair</i>		25. DATE RECD. BY LOCAL REG. <i>3-26-57</i>	
		26. REGISTRAR'S SIGNATURE <i>Floyd Williams</i>	

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

*Not Embalmed
Sherwood W. Mitchell*

Signed.....

Licensed Embalmer No.....

P. O. Address.....

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.