

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

59-010105

State File No. \_\_\_\_\_

FILED MAR 23 1959

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. 1 PRIMARY REG. DIST. NO. 2 Registrar's No. 73

1. PLACE OF DEATH a. COUNTY <u>Livingston</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>Livingston</u>	
b. CITY (If outside corporate limits, write RURAL and give township) <u>Chillicothe Mo.</u>		c. LENGTH OF STAY (In this place) <u>Life</u>	c. CITY OR TOWN <u>Chillicothe</u> <u>0592</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>929 Elm St.</u>		e. STREET ADDRESS (If rural, give location) <u>929 Elm Street</u>	

3. NAME OF DECEASED (Type or Print) a. (First) <u>Milton</u> b. (Middle) <u>J.</u> c. (Last) <u>Rice</u>			4. DATE OF DEATH (Month) (Day) (Year) <u>Mar. 6, 1959</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>July 1, 1988</u>	9. AGE (In years last birthday) <u>70</u> IF UNDER 1 YEAR: Months _____ Days _____ IF UNDER 24 HRS: Hours _____ Mins. _____
10a. USUAL OCCUPATION (Give kind of work during most of working life, even if retired) <u>Insurance</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Insurance</u>		11. BIRTHPLACE (City and State or Foreign Country) <u>Dawn, Missouri.</u>
13a. FATHER'S NAME <u>Martin Rice</u>		13b. MOTHER'S MAIDEN NAME <u>Margueret Williams</u>		14. NAME OF HUSBAND OR WIFE <u>Lora Rice</u>

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u> <u>No.</u>		16. SOCIAL SECURITY NO. <u>500-84-7460</u>	17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>Mrs. Milton Rice Chillicothe, 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, asthma, etc. It means the disease, injury, or complication which caused death.	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Acute Coronary Thrombosis</u>		INTERVAL BETWEEN ONSET AND DEATH <u>One Day</u>
	ANTECEDENT CAUSES Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____ <u>4201</u>		
	II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>Chr. myocarditis</u>		
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION		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) (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 8/22/56 to 2/25/59, that I last saw the deceased alive on 2/25/59 and that death occurred at 9:40 a.m., from the causes and on the date stated above.

23a. SIGNATURE <u>M. A. Dowell</u> (Degree or title)	23b. ADDRESS <u>Chillicothe Mo</u>	23c. DATE SIGNED <u>2/9/59</u>
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	24b. DATE <u>Mar. 9, 1959</u>	24c. NAME OF CEMETERY OR CREMATORY <u>D.W. Newcomers, Crematory</u>
24d. LOCATION (City, town, or county) <u>Kansas City Mo.</u>		

DATE REC'D BY LOCAL REG. <u>3/19/59</u>	REGISTRAR'S SIGNATURE <u>Francis B Neill</u>	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Earl M. Kump Chillicothe Mo</u>
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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 *Carl M. Keeney*.....

Licensed Embalmer No. *3517*

P. O. Address *Chillicothe*

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.