

Health,
Welfare
Public
Service

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-016857
STATE FILE NUMBER 526

FILED MAY 25 1959 Registration District No. 042 Primary Registration District No. 1000 Registrar's No. 526

1. PLACE OF DEATH a. COUNTY Buchanan		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Buchanan	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Joseph		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN St. Joseph Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 2610 Duncan St.,		Length of stay in lb 35 yrs.	d. STREET ADDRESS (If outside, give location) 2610 Duncan St., Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First Florence Middle Estelle Last Rice			4. DATE OF DEATH Month May Day 16, Year 1959		
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan. 19, 1877	9. AGE (In years last birthday) 82	IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home	11. BIRTHPLACE (City and state or country) Kansas	12. CITIZEN OF WHAT COUNTRY? USA	
13a. FATHER'S NAME Charles Porter		13b. MOTHER'S MAIDEN NAME Mary Arthur		14. NAME OF HUSBAND OR WIFE Jasper Newton Rice	

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. none	17. INFORMANT Mrs. Delia Armstrong, St. Joseph, Missouri Address
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cerebrovascular accident		INTERVAL BETWEEN ONSET AND DEATH 1 wk
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) Generalized arteriosclerosis	
	PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) 331X	

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 <input type="checkbox"/> Month, Day, Year <input type="checkbox"/> a.m. <input type="checkbox"/> p.m. <input type="checkbox"/>	

20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> WORK <input type="checkbox"/> 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 902 Edmund	COUNTY St. Joseph	STATE Missouri
21. I attended the deceased from 5/2/59 to 5/8/59 and last saw her alive on 5/8/59 Death occurred at 8:45 a. m. on the date stated above; and to the best of my knowledge, from the causes stated.				
22a. SIGNATURE Dr. G.T. Carpenter M.D. (Degree or title)		22b. ADDRESS		22c. DATE SIGNED 5/18/59

23a. BURIAL, CREMATION, REMOVAL (Specify) Funeral	23b. DATE May 19, 1959	23c. NAME OF CEMETERY OR CREMATORY Kidwell Cemetery	23d. LOCATION (City, town, or county) Martinsville, Missouri	
24. FUNERAL DIRECTOR Wendell H. Hooper		ADDRESS St. Joseph, Missouri	25. DATE RECD. BY LOCAL REG. May 18, 1959	26. REGISTRAR'S SIGNATURE Mrs. Clark Goodell

(Licensed Embalmer's Statement on Reverse Side)

All diseases in Part I must be causally related.
Dr. G.T. Carpenter
USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

300
1-57

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



Licensed Embalmer No. 4679.....

P. O. Address St. Joseph, Mo.

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.