

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-027105

FILED VS AUG 11 1959

2 7078

STATE FILE NUMBER

Registration District No. \_\_\_\_\_ Primary Registration District No. \_\_\_\_\_ Registrar's No. \_\_\_\_\_

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>St. Louis</b>		Length of stay in 1b <b>5 Yrs.</b>	c. CITY OR TOWN <b>St. Louis</b> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>5321 Labadie Ave.</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <b>5321 Labadie Ave.</b> Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <b>Edgar</b> Middle <b>B.</b> Last <b>Rice</b>	4. DATE OF DEATH Month <b>7</b> Day <b>28</b> Year <b>1959</b>
---	---

5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>12/19/79</b>	9. AGE (last birthday) <b>79</b>	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HR Hours _____ Min. _____
-----------------------	----------------------------------	---	-------------------------------------	-------------------------------------	--	--

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Guard (ret.)</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>Aalco Valve Co.</b>	11. BIRTHPLACE (City and state or country) <b>St. Johns, Mich.</b>	12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>
--	---	---	--

13a. FATHER'S NAME <b>Unknown</b>	13b. MOTHER'S MAIDEN NAME <b>Unknown</b>	14. NAME OF HUSBAND OR WIFE <b>Evah Mock Rice</b>
--------------------------------------	---	--

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>	16. SOCIAL SECURITY NO. <b>191-18-9743</b>	17. INFORMANT Address <b>Mrs. Evah M. Rice, 5321 Labadie</b>
---	---	---

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CARCINOMA OF ESOPHAGO-GASTRIC</b> CONDITIONS, IF ANY, WHICH GAVE RISE TO ABOVE CAUSE (a), STATING THE UNDERLYING CAUSE LAST: <b>150x</b> DUE TO (b) <b>JUNCTION WITH METASTASES</b> DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH <b>5 YRS</b>
--	--	--

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)	PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
---	--

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 _____ a.m. _____ p.m. Month, Day, Year _____	20d. INJURY OCCURRED WHILE AT WORK <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 COUNTY STATE
---	--	--	---

21. I attended the deceased from **Aug 29 1958** to **July 28, 1959** and last saw <sup>her</sup> him alive on **July 27, 1959**  
Death occurred at **July 28, 1959 9:30 P** m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) <b>Herbert Sweet MD</b>	22b. ADDRESS <b>50 P N Grand</b>	22c. DATE SIGNED <b>7/28/59</b>
---	-------------------------------------	------------------------------------

23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Cremation</b>	23b. DATE <b>7/31/59</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Valhalla Crematory</b>	23d. LOCATION (City, town, or county) (State) <b>St. Louis County, Mo.</b>
---	-----------------------------	---	---

24. FUNERAL DIRECTOR ADDRESS <b>Drehmann-Harral, 1905 Union Blvd.</b>	25. DATE RECD. BY LOCAL REG. <b>JUL 31 '59</b>	26. REGISTRAR'S SIGNATURE <b>Earl Smith, M.D.</b>
--	---	--

BY AFFIDAVIT OF MEDICAL CERTIFICATION DOCUMENT

*M. J. B.*

01 2-7360  
Hrs. 2:30-5 Wed. No Hrs. Thurs.

**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by \_\_\_\_\_  
or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_

working under my personal supervision.

Student \_\_\_\_\_

Signature of Student Embalmer

Signed Warren A. Carver

Licensed Embalmer No. 353

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.