

URI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

'59 0 4 3 7 7 4

FILED VS DEC 3 0 1959

STATE FILE NUMBER

INDEXED

Registration District No. 29 Primary Registration District No. _____ Registrar's No. _____

34

1. PLACE OF DEATH a. COUNTY <u>DeKalb</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>DeKalb</u>	
b. CITY (if outside corporate limits, give TOWNSHIP only) OR TOWN <u>Maysville</u>		Length of stay in 1b <u>17 days</u>	c. CITY OR TOWN <u>Stewartsville</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (if NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Sunset Rest Home</u>		Inside/Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	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) First Middle Last <u>Willis Leslie Dice Sr.</u>			4. DATE OF DEATH Month Day Year <u>12-18-1959</u>			
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5. SEX <u>Male</u>	6. COLOR OR RACE <u>white</u>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>10/31/1880</u>	9. AGE (last birthday) <u>79</u>	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HR Hours Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Ret. Farmer</u>	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) <u>DeKalb Co. Mo</u>	12. CITIZEN OF WHAT COUNTRY <u>USA</u>
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13a. FATHER'S NAME <u>George W. Dice</u>	13b. MOTHER'S MAIDEN NAME <u>Martha Thompson</u>	14. NAME OF HUSBAND OR WIFE <u>Henrietta A. Dice</u>
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>	16. SOCIAL SECURITY NO. <u>499-20-2190</u>	17. INFORMANT Address <u>Loren Dice, Hemple, Mo.</u>
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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:		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u>	<u>20 hrs</u>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.		
DUE TO (b) <u>arteriosclerosis</u>	<u>?</u>	
DUE TO (c)		
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 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.)
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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
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21. I attended the deceased from <u>Dec 2, 1959</u> to <u>Dec 18, 1959</u> and last saw him alive on <u>12/17/59</u> Death occurred at <u>2:15 A.M.</u> on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) <u>Stewart Fowler MD</u>	22b. ADDRESS <u>Maysville Mo</u>	22c. DATE SIGNED <u>12/18/59</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>12-20-59</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Stewartsville</u>	23d. LOCATION (City, town, or county) (State) <u>Stewartsville, Mo.</u>
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24. FUNERAL DIRECTOR ADDRESS <u>WE Summerfield, Stewartsville Mo</u>	25. DATE RECD. BY LOCAL REG. <u>12-24-59</u>	26. REGISTRAR'S SIGNATURE <u>KARCOE Davidson</u>
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DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

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 D.E. Summerfield

Licensed Embalmer No. 3007

P. O. Address Stewartsville

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.