

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

Registration District No. **318** HC-455988 SL 134003 Registrar's No. **8919** -61-034836 STATE FILE NUMBER

DATE AMENDED

INSTEAD OF

ITEM NO. SHOULD READ

FILED OCT 13 1961

BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>ILLINOIS</b> b. COUNTY		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>ST. LOUIS, MO.</b>		Length of stay in 1b <b>9 DAYS</b>	c. CITY OR TOWN <b>MADISON</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>VET ADM HOSPITAL</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <b>201 HILL STREET</b>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>THOMAS</b> Middle <b>RICHARD</b> Last <b>RICE</b>			4. DATE OF DEATH Month <b>SEPTEMBER</b> Day <b>21</b> Year <b>1961</b>		
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>NEGRO</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>10-15-92</b>	9. AGE (last birthday) <b>68</b> IF UNDER 1 YEAR IF UNDER 24 HR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>LABORER</b>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) <b>NEW LIBERTY, ILLINOIS</b>		12. CITIZEN OF WHAT COUNTRY <b>USA</b>
13a. FATHER'S NAME <b>JAMES THOMAS RICE</b>		13b. MOTHER'S MAIDEN NAME <b>MALINDA HOWELL</b>		14. NAME OF HUSBAND OR WIFE <b>BLANCHE RICE</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>YES</b> <b>WWI</b>			17. INFORMANT Address <b>BLANCHE RICE, 201 HILL ST., MADISON, ILL.</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>SHOCK</b>					INTERVAL BETWEEN ONSET AND DEATH <b>10 HOURS</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.		DUE TO (b) <b>MYOCARDIAL INFARCTION</b>		DUE TO (c) <b>584x</b>	
DUE TO (b) <b>FOLLOWING CHOLECYSTECTOMY</b>		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>CHOLECYSTITIS WITH CHOLELITHIASIS</b>			
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 checked="" 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.)			
20c. TIME OF INJURY Hour Month, Day, Year a.m. p.m.		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. VA attended the deceased from <b>9-12-61</b> to <b>9-21-61</b> and last saw <input checked="" type="checkbox"/> him alive on <b>9-21-61</b> Death occurred at <b>10:22 p.</b> m on the date stated above, and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE (Degree or title) <b>W. H. Smith, M.D.</b>			22b. ADDRESS <b>VAH, ST. LOUIS, MO.</b>		22c. DATE SIGNED <b>9-22-61</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>9/27/61</b>	23c. NAME OF CEMETERY OR CREMATORY <b>National</b>		23d. LOCATION (City, town, or county) (State) <b>Jefferson Barracks, Mo.</b>
24. FUNERAL DIRECTOR <b>Marshall Funeral Home - E. St. Louis, Ill.</b>		ADDRESS		25. DATE RECD. BY LOCAL REG. <b>SEP 26 1961</b>	26. REGISTRAR'S SIGNATURE <b>W. H. Smith, M.D.</b>

DOCUMENT

MEDICAL CERTIFICATION

**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 Thomas M. Lebsen

Licensed Embalmer No. 4479

P. O. Address East St. Louis, I

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.