

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-038056

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

STATE FILE NUMBER

Registration District No. 290 Primary Registration District No. _____ Registrar's No. 120

FILED OCT 18 1961

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

3. NAME OF DECEASED (Type or print) First RICHARD Middle RAYMOND Last RICE			4. DATE OF DEATH Month October Day 10 Year 1961		
5. SEX Male	6. COLOR OR RACE White	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 9-23-61	9. AGE (last birthday) Months 18 Days 18 Hours 18 Min. 18	IF UNDER 1 YEAR IF UNDER 24 HR
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) Fort Leonard Wood, Mo	
12. CITIZEN OF WHAT COUNTRY USA					

13a. FATHER'S NAME James Ronald Rice		13b. MOTHER'S MAIDEN NAME Takako Kotoni		14. NAME OF HUSBAND OR WIFE -	
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. -		17. INFORMANT James R. Rice Address Waynesville, Missouri	

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) Pneumonia, Bilateral		
DUE TO (b) Immaturity		
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.		
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	
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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 _____ 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 **Sep 23, 1961** to **Oct 10, 1961** and last saw **him** alive on **Oct 10, 1961**
Death occurred at **11:30 A.** on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE William D. Deupree, Captain, MC (Degree or title)	22b. ADDRESS US Army Hospital Fort Leonard Wood, Missouri	22c. DATE SIGNED 10-11-61
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23a. BURIAL, CREMATION, REMOVAL (Specify) Removed	23b. DATE 10/11/61	23c. NAME OF CEMETERY OR CREMATORY Unknown	23d. LOCATION (City, town, or county) (State) So San Francisco California
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24. FUNERAL DIRECTOR Charles Moss ADDRESS Williams Funeral Homes Crocker Mo	25. DATE RECD. BY LOCAL REG. 10-11-61	26. REGISTRAR'S SIGNATURE Paula Spivey Anderson
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(Licensed Embalmer's Statement on Reverse Side)

AMENDED
 DATE AMENDED
 INSTEAD OF
 DOCUMENT
 MEDICAL CERTIFICATION
 SHOULD READ
 BY AFFIDAVIT OF
 ITEM NO.

DEC 14 1961

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 Clarence Amoss

Licensed Embalmer No. 4896

P. O. Address Waynesville, 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.