

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

=62-042075

STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. 77 Primary Registration District No. 3016 Registrar's No. 470

FILED DEC 1 3 1962

VS 300	DATE AMENDED
Rev. 4/59	
1 0269	
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AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF	
SHOULD READ	
BY AFFIDAVIT OF	

1. PLACE OF DEATH a. COUNTY <u>Cole</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MO</u> b. COUNTY <u>Cole</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>JEFFERSON CITY</u> Length of stay in 1b		c. CITY OR TOWN <u>JEFFERSON CITY</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>Capital Ave. Rest Home</u> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <u>611 E. Capitol Ave.</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Pearl</u> Middle <u>V.</u> Last <u>Rice</u>			4. DATE OF DEATH Month <u>Nov.</u> Day <u>30</u> Year <u>1962</u>
5. SEX <u>Female</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>Feb 4 - 1893</u>
9. AGE (last birthday) <u>79</u>		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) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>	11. BIRTHPLACE (City and state or country) <u>Callaway Co MO</u>
12. CITIZEN OF WHAT COUNTRY <u>USA.</u>		13a. FATHER'S NAME <u>Joseph Pearce</u>	
13b. MOTHER'S MAIDEN NAME <u>Mary E. Bitchy</u>		14. NAME OF HUSBAND OR WIFE <u>William Rice</u>	
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>NONE</u>	17. INFORMANT <u>Vest. Rice</u> Address <u>JEFFERSON CITY</u>
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>PNEUMONITIS, BILATERAL, TERMINAL</u>			<u>48 HRS.</u>
DUE TO (b) <u>ARTERIOSCLEROTIC HEART DISEASE</u>			<u>10 YEARS</u>
DUE TO (c) <u>GENERALIZED ARTERIOSCLEROSIS</u>			<u>15 YEARS</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>ARTERIOSCLEROTIC ENCEPHALOPATHY; FRACTURE, RT. HIP - 9-2-62</u>			PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" 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 checked="" 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 <u>JAN. 6, 1962</u> to <u>NOV. 30, '62</u> and last saw her alive on <u>NOV. 29, 1962</u> Death occurred at <u>2:45 p.m.</u> on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <u>Donald Shull M.D.</u>		22b. ADDRESS <u>521 E. High, Jefferson City, Mo.</u>	22c. DATE SIGNED <u>12-2-62</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE <u>Dec. 3 - 1962</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Union Hill Cemetery</u>	23d. LOCATION (City, town, or county) <u>Holla Summit MO</u>
24. FUNERAL DIRECTOR <u>Claypool Seume New Bloomfield</u> ADDRESS _____	25. DATE RECD. BY LOCAL REG. <u>8 December 1962</u>	26. REGISTRAR'S SIGNATURE <u>R. Harris, MD - Richter, Dep.</u>	

USE BLACK INK OR TYPEWRITER RIBBON

**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 LeRoy Claypool

Licensed Embalmer No. 4412

P. O. Address New Bloomfield 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.