MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

Do not use this space.

18547

JUN 26 1929

1. PLACE OF DEATH

County: Jasper — Registration District No. 417

Township: — Primary Registration District No. 3021

City: Webb City (No. ..... St. ..... Ward)

File No. ..... Registered No. 91

2. FULL NAME Russell L. Rice

(a) Residence. No. Same Place St. Hospital Ward.
(Usual place of abode) (If nonresident, give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)
Male	White	Married

5a. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) ~~WIFE~~ OF Clela Rice

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Nov 25 1894

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, ... hrs. or ..... min.
	34	5	19	

8. OCCUPATION OF DEASCED
(a) Trade, profession, or particular kind of work: Garage owner
(b) General nature of industry, business, or establishment in which employed (or employer): /
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) Dallas
(STATE OR COUNTRY) Texas

PARENTS

10. NAME OF FATHER C. A. Rice

11. BIRTHPLACE OF FATHER (CITY OR TOWN) .....
(STATE OR COUNTRY) Missouri

12. MAIDEN NAME OF MOTHER Ida L. Schooley

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) /
(STATE OR COUNTRY) Texas

14. INFORMANT Clela Rice
(Address) Joplin Mo.

15. FILED 5/16, 1929 R. M. Stormont REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) May 14 1929

17. I HEREBY CERTIFY, That I attended ~~deceased~~ from 4/18, 1929, to 5/14, 1929, that I last saw h. alive on 5/13, 1929, and that death occurred, on the date stated above, at 3 a.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Lymphosarcoma abdomen
117A
124 (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (SECONDARY) Prolonged Barbiturate Coma
Medical D.O. Treatments (duration) ..... yrs. ..... mos. ..... ds.

18. WHERE WAS DISEASE CONTRACTED? Home
IF NOT AT PLACE OF DEATH .....
DID AN OPERATION PRECEDE DEATH? No DATE OF 5/6-29
WAS THERE AN AUTOPSY? No
WHAT TEST CONFIRMED DIAGNOSIS? Clinical X Ray
(Signed) O. L. Dumbaugh M. D.
5/15, 1929 (Address) Webb City

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) Whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL	DATE OF BURIAL
Carterville Cem	5/16 1929
20. UNDERTAKER	**ADDRESS**
Webb City Und. Co	Webb City Mo.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

WHITE PAPER, WITH CARBONS, MAKES THIS A PERMANENT RECORD

2-1-109