

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. 32256

Registration District No. 241

Primary Registration District No. 5-3-54 4047

Registrar's No. 1270

1. PLACE OF DEATH:

(a) County Dallas

(b) City or town Buffalo 2  
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution \_\_\_\_\_  
(Specify whether \_\_\_\_\_)

In this community \_\_\_\_\_  
years, months or days

3. (a) PRINT FULL NAME Baby Rice 2nd

3. (b) If veteran, name war \_\_\_\_\_

3. (c) Social Security No. \_\_\_\_\_

4. Sex Female 5. Color or race ✓

6. (a) Single, widowed, married, divorced \_\_\_\_\_

6. (b) Name of husband or wife \_\_\_\_\_

6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased Sept 1 1939  
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
				<u>4</u> hr. _____ min.

9. Birthplace Buffalo Mo  
(City, town, or county) (State or foreign country)

10. Usual occupation \_\_\_\_\_

11. Industry or business 0

MOTHER FATHER

12. Name Wilby Rice 0

13. Birthplace Mo. 0  
(City, town, or county) (State or foreign country)

14. Maiden name Seunle

15. Birthplace Mo  
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature Wilby Rice

(b) Address Buffalo Mo.

17. (a) Burial (b) Date thereof 9-2-1939  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Housing Mo.

18. (a) Signature of funeral director H. B. Jones

(b) Address Buffalo Mo.

19. (a) \_\_\_\_\_ (b) \_\_\_\_\_  
(Date received local registrar) (Registrar's signature) 5/11/54

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Dallas

(c) City or town Buffalo  
(If outside city or town limits, write "RURAL")

(d) Street No. \_\_\_\_\_  
(If rural, give location)

(e) If foreign born, how long in U. S. A.? \_\_\_\_\_ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept day 2  
year 1939 hour 3 minute 30 a.m.

21. I hereby certify that I attended the deceased from \_\_\_\_\_, 19\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_;

that I last saw \_\_\_\_\_ alive on \_\_\_\_\_, 19\_\_\_\_; and that death occurred on the date and hour stated above.

Immediate cause of death Asphyxia lvida from Cerebral hemorrhage phrs.

Due to (Pre-eclampsia toxemia in mother)

Due to \_\_\_\_\_

Other conditions \_\_\_\_\_  
(Include pregnancy within 3 months of death)

Major findings: \_\_\_\_\_

Of operations \_\_\_\_\_

Of autopsy None performed.

PHYSICIAN \_\_\_\_\_

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) \_\_\_\_\_

(b) Date of occurrence \_\_\_\_\_

(c) Where did injury occur? \_\_\_\_\_  
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? \_\_\_\_\_

While at work? \_\_\_\_\_ (Specify type of place)

(e) Means of injury \_\_\_\_\_

23. Signature Wend O. Gamm (M. D. or other) MD

Address Buffalo, Mo. Date signed 9-12-39

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

RECEIVED

District Health Officer No. 7,  
District File Number 16-39-1500  
Date Filed 4-0-13-39

**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.....  
....., Registered Apprentice No.....  
working under my personal supervision.

Signed.....  
Licensed Embalmer No.....  
P. O. Address.....

**Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply the above constitutes grounds for revocation of license.)**

**If this body is not embalmed, above space should be left blank.**

FILL IN ANSWERS TO ALL SPACES  
CHECKED IN RED PENCIL.

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

32256

Do not use this space.

1. PLACE OF DEATH

(a) County Dallas Registration District No. 24

(b) Township Buffalo Primary Registration District No. 4047

(c) City..... (d) Street No..... St.

(If death occurred in Hospital or Institution, write its name instead of street and number)

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

2. PRINT FULL NAME Baby Rice

(a) Residence, No. \_\_\_\_\_ St.  (If nonresident, give city or town and State)

(Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX 7 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word)

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF

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

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, _____ hrs. or _____ min.
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OCCUPATION

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc.....

9. Industry or business in which work was done, as saw mill, bank, etc.....

10. Date deceased last worked at this occupation (month and year)..... 11. Total time (years) spent in this occupation.....

12. BIRTHPLACE (CITY OR TOWN) Buffalo (STATE OR COUNTRY)

FATHER

13. NAME Wilby Rice

14. BIRTHPLACE (CITY OR TOWN) Buffalo (STATE OR COUNTRY)

MOTHER

15. MAIDEN NAME Bonnie Danner

16. BIRTHPLACE (CITY OR TOWN) Buffalo (STATE OR COUNTRY)

17. INFORMANT (ADDRESS) Wilby Rice  
Buffalo

18. BURIAL, CREMATION, OR REMOVAL

PLACE \_\_\_\_\_ DATE \_\_\_\_\_ 19

19. FUNERAL DIRECTOR (ADDRESS)

20. FILED 9/29 19 7 Tracy Moran  
Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Sept 2 1907

22. I HEREBY CERTIFY, That I attended deceased from \_\_\_\_\_ 19\_\_\_\_ to \_\_\_\_\_, 19\_\_\_\_

I last saw h..... alive on \_\_\_\_\_, 19\_\_\_\_. Death is said to have occurred on the date stated above, at 3:30 a.m.

The principal cause of death and related causes of importance were as follows:

Date of onset

Other contributory causes of importance:

Name of operation \_\_\_\_\_ Date of \_\_\_\_\_

What test confirmed diagnosis? \_\_\_\_\_ Was there an autopsy? \_\_\_\_\_

23. If death was due to external causes (violence), fill in also the following:

Accident, suicide, or homicide? \_\_\_\_\_ Date of injury \_\_\_\_\_, 19\_\_\_\_

Where did injury occur? \_\_\_\_\_ (Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place.

Manner of injury \_\_\_\_\_

Nature of injury \_\_\_\_\_

24. Was disease or injury in any way related to occupation of deceased? \_\_\_\_\_

If so, specify \_\_\_\_\_

(Signed) Claude O. Danner, M. D.

(Address) Buffalo

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED IN THE INSTRUCTIONS TO REGISTRARS. THE DEPARTMENT OF OCCUPATIONAL SAFETY IS VERY IMPORTANT.

S-32256