

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.

FILED FEB 8 1940

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

1649
Do not use this space.

1. PLACE OF DEATH
 (a) County Boone Registration District No. 73
 (b) Township Columbia Primary Registration District No. 3006
 (c) City Columbia (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. da. (f) How long in U. S., if of foreign birth? yrs. mos. da.

2. PRINT FULL NAME John F. Rice
 (a) Residence, No. 401 Melbourne 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 Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) married

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) 12-27-1860

7. AGE YEARS 79 MONTHS 1 DAYS 2 If LESS than 1 day, _____ hrs. or _____ min.

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

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

FATHER
 13. NAME Thomas Rice
 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Pennsylvania

MOTHER
 15. MAIDEN NAME Julia DeHart
 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Illinois

17. INFORMANT Alma Rice
 (ADDRESS) Columbia, Mo.

18. BURIAL, CREMATION, OR REMOVAL PLACE Memorial Park DATE 1-31-40

19. FUNERAL DIRECTOR (NAME) (ADDRESS) Parker's
Columbia, Mo.

20. FILED 1/30/40 Allie Selby
 Local Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 1-29-1940

22. I HEREBY CERTIFY, That I attended deceased from Jan. 29, 1940 to Jan. 29, 1940
 I last saw him alive on Jan. 29, 1940. Death is said to have occurred on the date stated above, at 5:55 A.M.
 The principal cause of death and related causes of importance were as follows:
Acute Coronary Occlusion
Chr. Myocarditis
 Date of onset _____

Other contributory causes of importance: _____

Name of operation _____ Date of _____
 What test confirmed diagnosis? _____ Was there an autopsy? Yes

23. If death was due to external causes (violence), fill in also the following:
 Accident, suicide, or homicide? No 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? Yes
 If so, specify _____
 (Signed) James M. Parker, M. D.
 (Address) Columbia, Mo.

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

W. H. Vandeventer

Licensed Embalmer No.

2494

P. O. Address

Columbia, TN

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