

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. 10973

Registration District No. 411

Primary Registration District No. 2002

Registrar's No. \_\_\_\_\_

1. PLACE OF DEATH:

(a) County Jefferies  
(b) City or town Roller  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: Greenham Hospital  
(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

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Barton  
(c) City or town Rural (Newport)  
(If outside city or town limits, write "RURAL")  
(d) Street No. \_\_\_\_\_ (If rural, give location)  
(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 24  
year 1941 hour 12 minute 15 P. M.  
21. I hereby certify that I attended the deceased from March 22 41  
1941, to March 24 1941;  
that I last saw him alive on March 24 1941;  
and that death occurred on the date and hour stated above.

Duration

Immediate cause of death: Pneumococcus Meningitis 4 days

Due to Influenza

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

PHYSICIAN

Major findings:  
Of operations \_\_\_\_\_

Of autopsy No

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? 37th  
(Specify type of place) \_\_\_\_\_  
While at work \_\_\_\_\_ (e) Means of injury \_\_\_\_\_

23. Signature [Signature] (M. D. or other) [Signature]  
Address \_\_\_\_\_ Date signed 3/24/41

3. (a) PRINT FULL NAME Earl Rice

3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Bessie Rice 6. (c) Age of husband or wife if alive 29 years

7. Birth date of deceased May 31, 1905  
(Month) (Day) (Year)

8. AGE: Years 35 Months 9 Days 23  
If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

9. Birthplace \_\_\_\_\_ (City, town, or county) Mo. 0 (State or foreign country)

10. Usual occupation Farmer

11. Industry or business \_\_\_\_\_

12. Name Maison Rice

13. Birthplace Mo. 9 (State or foreign country)

14. Maiden name Belle Minges

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

16. (a) Informant Wife

(b) Address Roller, Mo.

17. (a) Burial (b) Date thereof 3-26-41  
(Burial, cremation, or other) (Month) (Day) (Year)

(c) Place: burial or cremation Golden City, Mo.

18. (a) Signature of funeral director [Signature]  
(b) Address Roller, Mo.

19. (a) 3-25-41 (b) E. D. Jones  
(Date received local registrar) (Registrar's signature)

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

19  
2  
5

41-4-363

**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..... *R. W. Dwyer*.....

Licensed Embalmer No. *3141*

P. O. Address..... *Lamar, 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 this body is not embalmed, fact should be so stated above.**