

No. 2
4-13-40
5-17-39
DI X23159

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 13060

Registration District No. 791

Primary Registration District No. 1003

Registrar's No. 3490

1. PLACE OF DEATH:

(a) County.....

(b) City or town St. Louis
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:
Homer G. Phillips Hospital 0
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 9 days
(Specify whether years, months or days)

In this community 19 years
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County 000
1721

(c) City or town St. Louis
(If outside city or town limits, write "RURAL")

(d) Street No. 1922 a Franklin (Rear)
(If rural, give location)

(e) If foreign born, how long in U. S. A. 0 years.

3. (a) PRINT FULL NAME Tom Rice

(b) If veteran, name war.....

(c) Social Security No.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 22
year 1941 hour 1:40 minute A. M.

4. Sex M 5. Color or race NEGRO

6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Nancy Rice

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

7. Birth date of deceased Jan. 22 6 1941/18
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from March 13, 1941 to March 22, 1941, that I last saw him alive on March 22, 1941, and that death occurred on the date and hour stated above.

8. AGE: Years Months Days If less than one day

68 2 16 hr. min.

Immediate cause of death:
Bronchopneumonia
Rheumatic Heart Disease

Duration
3 days
2 yrs.

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

Due to.....

Due to.....

Other conditions 95
(Include pregnancy within 3 months of death)

10. Usual occupation Nil

11. Industry or business.....

MOTHER FATHER { 12. Name Tom Rice

13. Birthplace N. C.
(City, town, or county) (State or foreign country)

Major findings:
Of operations.....

Of autopsy Bronchopneumonia

PHYSICIAN
Underline the cause to which death should be charged statistically.

14. Maiden name Catherine Williams

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

16. (a) Informant Esther Mary Sherard

(b) Address 2601 N. Whittier St.

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

(a) Accident, suicide, or homicide (specify).....

17. (a) City Cemetery
(Burial, cremation, or removal)

(b) Date thereof 4/24/41
(Month) (Day) (Year)

(c) Place: burial or cremation CITY CEMETERY

(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?.....

18. (a) Signature of funeral director [Signature]

(b) Address [Address]

19. (a) APR 23 1941 (b) [Signature]
(Date received local registrar) (Registrar's signature)

While at work?.....
(Specify type of place)

(c) Means of injury [Signature]

23. Signature [Signature] (M. D. or other) 4-19-41
Address 2601 N. Whittier St. Date signed

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

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 with the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.