No. 2
1-4-41
17-39
X26390

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILLED OCT 13 1941

Registration District No. 377

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

Primary Registration District No. 1002

State File No. 30840

Registrar's No. 3598

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

1. PLACE OF DEATH:

(a) County Jackson

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

(c) Name of hospital or institution:
General Hospital #2 0
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 8-24-41-9-21-41 (Specify whether
In this community 2 years
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson 48

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

(d) Street No. 2115 Olive St. 0
(If rural, give location)

(e) Citizen of foreign country? No (Yes or No)

If yes, name country

3. (a) PRINT FULL NAME OBIE RICE

3. (b) If veteran, name war None

3. (c) Social Security No. None

4. Sex Male 2

5. Color or race Negro

6. (a) Single, widowed, married, divorced Widowed 2

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

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

7. Birth date of deceased October (Month) 19 (Day) 1874 (Year)

8. AGE:

Years	Months	Days	If less than one day
66	11	2	hr. min.

9. Birthplace Pine Bluff (City, town, or county) Arkansas / (State or foreign country)

10. Usual occupation Unemployed

11. Industry or business

FATHER
12. Name Deceased - Mason Rice
13. Birthplace Unknown 9 (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name Deceased
15. Birthplace 9 (City, town, or county) (State or foreign country)

16. (a) Informant Record Clerk
(b) Address General Hospital #2

17. (a) burial (Burial, cremation, or removal) (b) Date thereof 9/27/41 (Month) (Day) (Year)
(c) Place: burial or cremation Lincoln Cemetery

18. (a) Signature of funeral director Watkins Bros
(b) Address 1729 Lydia

19. (a) 9/27/43 (Date received local registrar) (b) M. M. Crowe (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept. day 21
year 1941 hour 11 minute 30 a. M.

21. I hereby certify that I attended the deceased from 8-24-41, 19__, to 9-21-41, 19__;
that I last saw him alive on September 21, 1941;
and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Congestive Heart failure with decompensation	
Due to Hypertensive type heart disease 9 3 D	
Due to	
Other conditions Generalized anasarca (Include pregnancy within 3 months of death)	

Major findings:
Of operations 9 3 D
Of autopsy

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?
(Specify type of place)
While at work? (e) Means of injury

23. Signature G C Dennis (M. D. or other)
Address Ten Hoy #2-600 E. 22 Date signed 9-23-41

(Licensed Embalmer's Statement on Reverse Side)

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 Isaac J. Manlove

Licensed Embalmer No. 3994

P. O. Address 2503 Highlan

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

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