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M-5-42
5-17-39
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104

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

15688

FILED MAY 15 1943
Registration District No. 245

Primary Registration District No. 6661

State File No. _____
Registrar's No. 6

1. PLACE OF DEATH:
(a) County Stone
(b) City or town Flat Creek Sp. Rural
(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

2. USUAL RESIDENCE OF DECEASED:
(a) State Mo (b) County Stone
(c) City or town Flat Creek Sp. Rural
(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 _____

3. (a) PRINT FULL NAME DAVID DEAN RICE
3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex M 5. Color or race W 6. (a) Single, widowed, married, divorced, Single
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased nov 14 1939 (Month) (Day) (Year)

8. AGE: Years 3 Months 4 Days 29 If less than one day _____ hr. _____ min.

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

10. Usual occupation none

11. Industry or business Adrain Rice

12. Name Adrain Rice 13. Birthplace Ky (City, town, or county) (State or foreign country)

14. Maiden name Vera Hedrick 15. Birthplace Mo (City, town, or county) (State or foreign country)

16. (a) Informant Fred Hedrick (b) Address Galena Mo RPO

17. (a) Burial (b) Date thereof apr 13/43 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director J. F. King (b) Address _____

19. (a) April 14 1943 (b) Rubye Arnold (Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month apr day 12 year 1943 hour 7:45 M.
21. I hereby certify that I attended the deceased from apr 10/43 to apr 12/43 that I last saw him alive on apr 10 and that death occurred on the date and hour stated above.

Immediate cause of death Streptococcus sore throat Duration 8 days

Due to _____

Due to _____

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

Major findings: Of operations _____

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? _____

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

23. Signature of _____ (M. D. or other) Address _____ Date signed 7/12/43

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

MOTHER FATHER

1-2-8-2

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED

District Health Officer No. 6,

District File Number

543-587

Date Filed

MAY 13 1943

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.....

not embalmed

....., 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.