

FILED AUG 7 1943

Registration District No. 247A16Primary Registration District No. 5338-5849Registrar's No. 55

## 1. PLACE OF DEATH:

(a) County Dallas  
 (b) City or town Rural Jasper Twp  
 (If outside city or town limits, write "RURAL" and name of township)  
 (c) Name of hospital or institution: 1

(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution. 18 Days (Specify whetherIn this community 18 Days  
years, months or days)3. (a) PRINT FULL NAME Bobbie 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. 306. (b) Name of husband or wife. .... 6. (c) Age of husband or wife if alive 30 years7. Birth date of deceased. Sept 24 - 1912  
(Month) (Day) (Year)8. AGE: Years Months Days If less than one day  
31 10 hr. min.9. Birthplace St Charles Mo.  
(City, town, or county) (State or foreign country)

10. Usual occupation. ....

11. Industry or business. ....

12. Name Gene L. Rice13. Birthplace Dallas Co Mo.  
(City, town, or county) (State or foreign country)14. Maiden name Sarah Ann Bilton15. Birthplace Rolla Mo.  
(City, town, or county) (State or foreign country)16. (a) Informant Gene L. Rice(b) Address Bennetts Springs Mo.17. (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 1-5-1943  
(Month) (Day) (Year)(c) Place: burial or cremation Lone Rock18. (a) Signature of funeral director Palma(b) Address LEBANON Mo.19. (a) 1/4/43 (Date received local registrar) (b) Helen Davis (Registrar's signature)

## 2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County Dallas 30  
 (c) City or town Rural 0  
 (If outside city or town limits, write "RURAL")

(d) Street No. Bennetts Springs  
(If rural, give location)(e) Citizen of foreign country? 0 (Yes or No)  
If yes, name country. ....

## MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 1 day 4  
year 1943 hour 4 minute 9 M.21. I hereby certify that I attended the deceased from 19 to 19that I last saw him alive on 19  
and that death occurred on the date and hour stated above.Immediate cause of death. Asphyxiation 4/3 Duration

Due to. ....

Due to. ....

Other conditions. ....  
(Include pregnancy within 3 months of death)Major findings: Asphyxiation  
Of operations. ....

Of autopsy. ....

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

(a) Accident, suicide, or homicide (specify) 030(a) Date of occurrence 1-5-1943(c) Where did injury occur? 1-5-1943  
(City or town) (County) (State)(d) Did injury occur in or about home, on farm, in industrial place, in public place? 1While at work? 1 (Specify type of place) (e) Means of injury 123. Signature Edith B. Boren (Name of other)Address Buffalo Mo. Date signed 1-5-1943

WRITE PLAIN - A PLAIN &amp; LEGIBLE RECORD

RECEIVED

District Health Officer No. 7

District File Number 7-43-748

Date Filed 8-6-43

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 Paul Hank

....., 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.

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. \_\_\_\_\_

Registration District No. 96

Primary Registration District No. 5349

Registrar's No. 0-5

1. PLACE OF DEATH:

(a) County Dallas

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

(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 \_\_\_\_\_ (Specify whether \_\_\_\_\_)  
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State \_\_\_\_\_ (b) County \_\_\_\_\_

(c) City or town \_\_\_\_\_ (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 Bobbie 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 s

6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased Sept 24 1914  
(Month) (Day) (Year)

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

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

10. Usual occupation \_\_\_\_\_ (Industry or business)

12. Name \_\_\_\_\_

13. Birthplace \_\_\_\_\_ (City, town, or county) (State or foreign country)

14. Maiden name \_\_\_\_\_ (City, town, or county) (State or foreign country)

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

16. (a) Informant \_\_\_\_\_ (b) Address \_\_\_\_\_

17. (a) \_\_\_\_\_ (b) Date thereof \_\_\_\_\_ (Month) (Day) (Year)  
(Burial, cremation, or removal)

(c) Place: burial or cremation \_\_\_\_\_

18. (a) Signature of funeral director \_\_\_\_\_ (b) Address \_\_\_\_\_

19. (a) \_\_\_\_\_ (b) \_\_\_\_\_ (Registrar's signature)  
(Date received local registrar)

20. DATE OF DEATH: Month \_\_\_\_\_ day \_\_\_\_\_ year \_\_\_\_\_ hour \_\_\_\_\_ minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_, 19\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_, and that I saw him \_\_\_\_\_ alive on \_\_\_\_\_, 19\_\_\_\_, and that death occurred on the date and hour stated above.

Immediate cause of death asphyxiation Duration \_\_\_\_\_

Due to bed

Due to no inquest

Other conditions \_\_\_\_\_ (include pregnancy within 3 months of death)

Major findings: \_\_\_\_\_

Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

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? \_\_\_\_\_

23. Signature L. J. James Colones (M. D. or other) \_\_\_\_\_

Address Buffalo, Mo Date signed \_\_\_\_\_

While at work? \_\_\_\_\_ (Specify type of place) \_\_\_\_\_ (2) Means of injury \_\_\_\_\_

WRITE PL. IN. USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

SUPPLEMENTARY

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

S. 24502