

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

FILED 'SEP 6 1944

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

27501

Do not use this space.

1. PLACE OF DEATH

(a) County Christian Registration District No. 67
(b) Township Sparta Primary Registration District No. 5266 Registered No. 5
(c) City _____ (d) Street No. _____ St.
(If death occurred in Hospital or Institution, write its name instead of street and number)
(e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME Buxler Franklin Rice

(a) Residence, No. _____ St. (If nonresident, give city or town and State)
(Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX <u>Male</u>	4. COLOR OR RACE <u>White</u>	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) <u>Widowed</u>
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF <u>Widowed</u>		
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) <u>July 14 - 1867</u>		
7. AGE	YEARS <u>77</u>	MONTHS <u>1</u>
	DAYS <u>1</u>	If LESS than 1 day, hrs. or min.
OCCUPATION	8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. <u>Farmer</u>	
	9. Industry or business in which work was done, as saw mill, bank, etc.	
	10. Date deceased last worked at this occupation (month and year)	
	11. Total time (years) spent in this occupation	
12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>Ohio</u>		
FATHER	13. NAME <u>Franklin Rice</u>	
	14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>Ohio</u>	
MOTHER	15. MAIDEN NAME <u>Amanda Butler</u>	
	16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>Ohio</u>	
17. INFORMANT (ADDRESS) <u>Geo Gibson Sparta Mo</u>		
18. BURIAL, CREMATION, OR REMOVAL		
PLACE	DATE	
<u>Winged</u>	<u>Aug 16 1944</u>	
19. FUNERAL DIRECTOR (NAME) (ADDRESS) <u>Otto Kuhn Sparta Mo</u>		
20. FILED <u>8-14-1944</u> <u>Mrs S. M. Johnson</u> Local Registrar		

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Aug 15 1944

22. I HEREBY CERTIFY, That I attended deceased from Aug - 14 - 1944 to Aug - 15 - 1944
I last saw him alive on Aug - 14 - 1944. Death is said to have occurred on the date stated above, at 10:55 A. m.
The principal cause of death and related causes of importance were as follows:
Cerebral Hemorrhage
Basal
Date of onset _____

Other contributory causes of importance:
vascular hypertension

Name of operation _____ Date of _____
What test confirmed diagnosis? _____ Was there an autopsy? _____

23. If death was due to external causes (violence), fill in also the following:
Accident, suicide, or homicide? _____ Date of injury _____, 19____
Where did injury occur? _____ (Specify city or town, county, and State)
Specify whether injury occurred in industry, in home, or in public place. _____

Manner of injury _____
Nature of injury _____

24. Was disease or injury in any way related to occupation of deceased? _____
If so, specify _____
(Signed) Harold W. Nelson, M. D.
(Address) Sparta, Mo.

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 T. B. Chaffin

Licensed Embalmer No. 2182

P. O. Address Clark

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, above space should be left blank.