

FILED MAR 24 1947

Registration District No. _____

Primary Registration District No. 1003

Registrar's No. 2732

1. PLACE OF DEATH:

(a) County St. Louis
(b) City or town St. Louis
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
Park Lane Hospital
(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 Missouri (b) County St. Louis 96
(c) City or town Ferguson NR 0
(If outside city or town limits, write "RURAL")
(d) Street No. R. R. General Delivery NR 0
(If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME

Augusta Rice

(b) If veteran, name war No

(c) Social Security No. None

4. Sex Female 5. Color or race White

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

6. (b) Name of husband or wife Henry Rice 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased March 27 1885
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
61 11 16 hr. _____ min.

9. Birthplace St. Francois Co. Missouri
(City, town, or county) (State or foreign country)

10. Usual occupation Housewife

11. Industry or business

12. Name William Kain

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

14. Maiden name Mary Crusty

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

16. (a) Informant Lulu Belle Palafox

(b) Address 1434 Belt Ave.

17. (a) Burial (b) Date thereof 3-15-47
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Flat River, Mo.

18. (a) Signature of funeral director Albert H. Hoppe

(b) Address 4700 Washington Blvd.

19. (a) MAR 14 1947 (b) J. J. Pundack
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 13
year 1947 hour 7 minute 0 M.

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

Immediate cause of death Coronary Aneurysm Duration 6 hrs.
Lobar pneumonia 5 days
fractured at femur - 6 wks.
(with trichinosis)

Due to _____
Due to _____

Other conditions (Include pregnancy within 3 months before death) 3/14/47
Major findings: Of operations 16

Of autopsy 18
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) fractured at femur

(b) Date of occurrence Jan 17 - 47

(c) Where did injury occur? Home - 1434 Belt St Louis Mo
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place?
Home - 1434 Belt St Louis Mo

(e) Name Home - 1434 Belt St Louis Mo (Specify type of place)

While at work? _____ (e) Means of injury Fall

23. Signature Wm. Kain M.D. (M. D. or other)
Address 820 1/2 Broadway Date signed 3/13/47

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

MOTHER FATHER

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..... *R. W. Wilkison*

Licensed Embalmer No..... *3575*

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.