

FILED MAY 20 1947

Registration District No. **149**

Primary Registration District No. **1002**

Registrar's No. **2025**

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:
805 Penn. Street /
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 40 years (Specify whether years, months or days)

In this community 40 years (Specify whether years, months or days)

3. (a) PRINT FULL NAME Sarah Elizabeth Rice

3. (b) If veteran, name war None

3. (c) Social Security No. None

4. Sex Female

5. Color or race White

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

6. (b) Name of husband or wife Samuel E. Rice

6. (c) Age of husband or wife if alive 88 years

7. Birth date of deceased June 6 1858
(Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
<u>88</u>	<u>10</u>	<u>26</u>	<u>hr. min.</u>

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

10. Usual occupation Housewife

11. Industry or business _____

MOTHER FATHER { 12. Name Knute Hickie

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

14. Maiden name Unknown

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

16. (a) Informant Mrs. T. R. Shedden

(b) Address Salina, Kansas

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 5-6-47
(Month) (Day) (Year)

(c) Place: burial or cremation Greenlawn

18. (a) Signature of funeral director Weilert Funeral Home

(b) Address Kansas City, Mo.

19. (a) 5-6-47 (Date received local registrar) (b) Thelma Holmes (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson **48**

(c) City or town Kansas City **2**
(If outside city or town limits, write "RURAL")

(d) Street No. 805 Penn Street **8**
(If rural, give location)

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

If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 2nd
year 1947 hour 2:20PM minute _____ M.

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

Immediate cause of death _____

Coronary Sclerosis

Due to _____

Due to _____

Other conditions _____
(Include pregnancy within 3 months)

Major findings:
Of operations _____

Of autopsy History & Inspection

PHYSICIAN _____

Underline the cause to which death should be assigned 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)

23. Signature W. E. Upsher (M. or other)
Address 2800 Main **5/5/47**

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.....

Blaine E. Weibert

Licensed Embalmer No.....

4075

P. O. Address.....

K.C. MO.

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.