S. No. 2
M—1/47
. 5-17-39

FEDERAL SECURITY AGENCY
National Office of Vital Statistics

MISSOURI DIVISION OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 24346

FILED AUG 4 1947 #64593

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 6912

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

1. PLACE OF DEATH:

(a) County

(b) City or town St.Louis,Mo. (If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: St.Louis City Hospital-Max C. Starkloff Memorial (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 000

(c) City or town St.Louis 17 (If outside city or town limits, write "RURAL")

(d) Street No. 21 2204 Cass Ave., 9 (If rural, give location)

(e) Citizen of foreign country? no (Yes or No) 1

If yes, name country

3. (a) PRINT FULL NAME SIM RICE

3. (b) If veteran, name war unknown

3. (c) Social Security No. unknown

4. Sex Male

5. Color or race White

6. (a) Single, widowed, married, divorced Divorced 3

6. (b) Name of husband or wife Mrs. Sim Rice

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

7. Birth date of deceased October (Month) 17th (Day) 1897 ~~Unknown~~ (Year)

8. AGE: Years 49 Months 9 Days 7 If less than one day hr. min.

9. Birthplace Webster County, Missouri 0 (City, town, or county) (State or foreign country)

10. Usual occupation Laborer

11. Industry or business

FATHER
12. Name Calvin Rice 1
13. Birthplace Tenn. (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name Mary Unknown
15. Birthplace Tenn. 1 (City, town, or county) (State or foreign country)

16. (a) Informant Rex Rainey

(b) Address Marshfield, Missouri.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 7/25/47 (Month) (Day) (Year)

(c) Place: burial or cremation Marshfield, Missouri.

18. (a) Signature of funeral director Rex Rainey

(b) Address Marshfield Mo.

19. (a) JUL 24 1947 (Date received local registrar) (b) J. F. Bredeck (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 24th year 1947 hour 2:50 minute A M.

21. I hereby certify that I attended the deceased from 11/7/47 19 to July 24th, 1947 19; that I last saw him alive on July 24th, 1947 19; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Anemia, secondary	3-4 mo
Due to: Squamous cell Carcinoma rt cheek, metastatic to	
Due to: Regional nodes rt mandible. Internal cheek, primary site	
Other conditions (Include pregnancy within 3 months of death)	

Major findings:
Of operations
Of autopsy

45

PHYSICIAN

Underline the cause of 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? (Specify type of place)

While at work? (e) Means of injury 0

23. Signature Joseph E. Flynn M.D.

Address 1515 Lafayette Date signed 7/24/47

Jefferson City Printing Co. (Licensed Embalmer's Statement on Reverse Side)

14th Market

AUG 7 19

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.....

Licensed Embalmer No. 3312

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.