

FILED OCT 13 1949

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. 32670

BIRTH NO. _____		REG. DIST. NO. <u>329</u>		PRIMARY REG. DIST. NO. <u>4473</u>		Registrar's No. <u>36</u>	
1. PLACE OF DEATH a. COUNTY <u>Saline</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.) a. STATE <u>Mo</u> b. COUNTY <u>Saline</u>			
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Blackburn</u>		c. LENGTH OF STAY (in this place) <u>4 years</u>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Blackburn Mo</u>			
d. FULL NAME OF HOSPITAL OR INSTITUTION _____				d. STREET ADDRESS (If rural, give location) _____			
3. NAME OF DECEASED (Type or Print)			a. (First) <u>Sarah</u> b. (Middle) <u>Catherine</u> c. (Last) <u>Tice</u>			4. DATE OF DEATH (Month) (Day) (Year) <u>Oct 1 1949</u>	
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Widowed</u>		8. DATE OF BIRTH <u>March 20 - 1876</u>	
9. AGE (In years last birthday) <u>73</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housekeeper</u>		10b. KIND OF BUSINESS OR INDUSTRY _____		9. AGE (In years last birthday) <u>6</u> 10. UNDER 1 YEAR Months <u>11</u> 11. UNDER 1 HR. Hours _____ Min. _____	
11. BIRTHPLACE (State or foreign country) <u>Fairville Mo</u>				12. CITIZEN OF WHAT COUNTRY? _____			
13a. FATHER'S NAME <u>William Trent</u>			13b. MOTHER'S MAIDEN NAME <u>Nelen Gaudin</u>			14. NAME OF HUSBAND OR WIFE <u>Adolph Tice</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) _____		16. SOCIAL SECURITY NO. _____		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>Mrs. George Bochner Blackburn</u>			
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)  * This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.				MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Chronic myocarditis</u> INTERVAL BETWEEN ONSET AND DEATH <u>3-4 yrs</u> ANTECEDENT CAUSES <u>Paraneoplasia of the Gall Bladder</u> Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>Paraneoplasia of the Gall Bladder</u>			
19a. DATE OF OPERATION _____		19b. MAJOR FINDINGS OF OPERATION _____				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT SUICIDE HOMICIDE (Specify) _____		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) _____		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.) _____		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? _____			
22. I hereby certify that I attended the deceased from <u>Jan 1946</u> to <u>Oct 1, 1949</u> that I last saw the deceased alive on <u>Oct 1, 1949</u> and that death occurred at <u>4:30 p.m.</u> , from the causes and on the date stated above.							
23a. SIGNATURE (Degree or title) <u>Davidas Kelling M.D.</u>				23b. ADDRESS <u>Waverly Mo</u>		23c. DATE SIGNED <u>10/4/49</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		24b. DATE <u>Oct 2-1949</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Blackburn</u>		24d. LOCATION (City, town, or county) (State) <u>Blackburn Mo</u>	
DATE REC'D BY LOCAL REG. <u>10/6/49</u>		REGISTRAR'S SIGNATURE <u>Sally Andrew</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Al Munneshagen</u>		ADDRESS <u>Blackburn Mo</u>	

(Licensed Embalmer's Statement on Reverse Side)

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

RECEIVED OCT 10  
District Health Officer No. 8.  
District File Number \_\_\_\_\_  
Date Filed 10-10-49

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 \_\_\_\_\_

Student Embalmer No. \_\_\_\_\_

working under my personal supervision.

Student .....  
Student Embalmer

Signed Roy F Weger  
2883 Licensed Embalmer No. Higginsville

P. O. Address \_\_\_\_\_ M

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.