

FILED JUN 6 1950

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **17323**

BIRTH NO. _____ REG. DIST. NO. **383** PRIMARY REG. DIST. NO. **2037** Registrar's No. **334**

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

1. PLACE OF DEATH a. COUNTY Lawrence		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Mo. b. COUNTY Lawrence	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Mt. Vernon		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Mt. Vernon 0551	
d. FULL NAME OF HOSPITAL OR INSTITUTION Residence		d. STREET ADDRESS (If rural, give location) 324 West Cherry	
3. NAME OF DECEASED (Type or Print) a. (First) George b. (Middle) Allie c. (Last) Rice		4. DATE OF DEATH (Month) (Day) (Year) 5-21-1950	
5. SEX M	6. COLOR OR RACE w	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH 3-9-1880
9. AGE (In years last birthday) 70		10. AGE (In years) IF UNDER 1 YEAR: (Month) (Day) (Hour) (Min.) 2 12	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) L		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Ringold Co. Iowa		12. CITIZEN OF WHAT COUNTRY? U	
13a. FATHER'S NAME Coleman S. Rice		13b. MOTHER'S MAIDEN NAME Nancy Armstrong	
14. NAME OF HUSBAND OR WIFE Mary Rice		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) L (If yes, give year or dates of service)	
16. SOCIAL SECURITY NO. 448-10-7964		17. INFORMANT'S SIGNATURE OR NAME Mary Rice ADDRESS Mt. Vernon	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))		MEDICAL CERTIFICATION	
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cardiac decompensation		INTERVAL BETWEEN ONSET AND DEATH 8 days	
*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.		ANTECEDENT CAUSES	
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.		DUE TO (b) Possible coronary occlusion	
DUE TO (c) Arteriosclerosis		II. OTHER SIGNIFICANT CONDITIONS	
Conditions contributing to the death but not related to the disease or condition causing death.		4201	
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"/>	
22. I hereby certify that I attended the deceased from _____, 19____, to 5/21, 1950 , that I last saw the deceased alive on 5/21, 1950 , and that death occurred at 11:23 P.M. , from the causes and on the date stated above.		22. HOW DID INJURY OCCUR?	
23a. SIGNATURE L. G. Weaver (Degree or title) M.D.		23b. ADDRESS Mt. Vernon Mo	
23c. DATE SIGNED 5/23/50		24. LOCATION (City, town, or county) (State) Mo.	
24a. BURIAL, CREMATION, REMOVAL (Specify) Buried		24b. DATE 5/23/50	
24c. NAME OF CEMETERY OR CREMATORY Grandy		24d. LOCATION (City, town, or county) (State) Mo.	
DATE REC'D BY LOCAL REG. May 23, 1950		REGISTRAR'S SIGNATURE Carl Handrick	
25. FUNERAL DIRECTOR'S SIGNATURE 4110 Morris-Lunion		ADDRESS Miller Mo.	

RECEIVED MAY 31 1950
District Health Office No. 5,
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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.....

A. R. Lesman

Licensed Embalmer No. 3297

P. O. Address Miller 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.