

FILED JUL 31 1950

THE DIVISION OF HEALTH - MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. 25211

318

1003

6407

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. \_\_\_\_\_ PRIMARY REG. DIST. NO. \_\_\_\_\_ Registrar's No. \_\_\_\_\_

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis		b. COUNTY Saline	
c. LENGTH OF STAY (In this place)		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Harrisburg 8120	
d. FULL NAME OF HOSPITAL OR INSTITUTION Barnes Hospital		d. STREET ADDRESS (If rural, give location) 115 West Park 8	

3. NAME OF DECEASED (Type or Print)			4. DATE OF DEATH (Month) (Day) (Year)					
a. (First) James			July 25 1950					
b. (Middle) Arthur								
c. (Last) Rice								
5. SEX Male 0	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married 1	8. DATE OF BIRTH June 8, 1895	9. AGE (In years last birthday) 55	10. MONTHS	11. DAYS	12. HOURS	13. MIN.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Stockkeeper		10b. KIND OF BUSINESS OR INDUSTRY N.Y.C. R.R.		11. BIRTHPLACE (State or foreign country) Illinois		12. CITIZEN OF WHAT COUNTRY? U.S.		

13a. FATHER'S NAME Charles Rice	13b. MOTHER'S MAIDEN NAME Josephine Johnson	14. NAME OF HUSBAND OR WIFE Laura
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No	16. SOCIAL SECURITY NO. Unknown	17. INFORMANT'S SIGNATURE OR NAME Laura Rice, 115 W. Park, Harrisburg, Ill.	ADDRESS
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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		INTERVAL BETWEEN ONSET AND DEATH
	1. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Uremia		3 wks.
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Malignant hypertension DUE TO (c) Arterionephrosclerosis		5 yrs. 5 yrs plus
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
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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? HFX

22. I hereby certify that I attended the deceased from July 8, 1950, to July 25, 1950, that I last saw the deceased alive on July 25, 1950, and that death occurred at 12:30pm., from the causes and on the date stated above.

23a. SIGNATURE R. Bradley 0 (Degree or title) M.D.	23b. ADDRESS BARNES HOSPITAL	23c. DATE SIGNED 7/25/50
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24a. BURIAL, CREMATION, REMOVAL (Specify) Removal	24b. DATE 7-25-50	24c. NAME OF CEMETERY OR CREMATORY Lindell Memorial Gardens	24d. LOCATION (City, town, or county) (State) Harrisburg, Ill.
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DATE REC'D BY LOCAL REG. JUL 26 1950	REGISTRAR'S SIGNATURE J. B. Foster	25. FUNERAL DIRECTOR'S SIGNATURE Albert H. Hoppe, 4700 Washington Blvd.	ADDRESS
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

2089

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 me

working under my personal supervision.

Student Embalmer No. ....

Signed [Signature]

Signed.....

Student Embalmer

Licensed Embalmer No. 4699

P. O. Address [Signature]

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.