

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

19838

FILED JUL 2 1956

State File No. \_\_\_\_\_

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. 33 PRIMARY REG. DIST. NO. 3010 Registrar's No. 326

|                                                                                                    |  |                                                                                                                                           |  |
|----------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------|--|
| 1. PLACE OF DEATH<br>a. COUNTY <u>CAPE GIRARDEAU</u>                                               |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).<br>a. STATE <u>MISSOURI</u> b. COUNTY <u>SCOTT</u> |  |
| b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>CAPE GIRARDEAU</u> |  | c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>CHAFFEE</u>                                               |  |
| c. LENGTH OF STAY (in this place) <u>8 DAYS</u>                                                    |  | d. STREET ADDRESS (If rural, give location) <u>206 WRIGHT</u>                                                                             |  |
| d. FULL NAME OF HOSPITAL OR INSTITUTION <u>SOUTHEAST MISSOURI HOSPITAL</u>                         |  |                                                                                                                                           |  |

|                                                                  |                          |                          |                           |                                                            |
|------------------------------------------------------------------|--------------------------|--------------------------|---------------------------|------------------------------------------------------------|
| 3. NAME OF DECEASED (Type or Print) <u>JOSEPH PERRY RICE SR.</u> | a. (First) <u>JOSEPH</u> | b. (Middle) <u>PERRY</u> | c. (Last) <u>RICE SR.</u> | 4. DATE OF DEATH (Month) (Day) (Year) <u>JUNE 28, 1956</u> |
|------------------------------------------------------------------|--------------------------|--------------------------|---------------------------|------------------------------------------------------------|

|                    |                               |                                                                       |                                     |                                           |                                                |                                             |
|--------------------|-------------------------------|-----------------------------------------------------------------------|-------------------------------------|-------------------------------------------|------------------------------------------------|---------------------------------------------|
| 5. SEX <u>MALE</u> | 6. COLOR OR RACE <u>WHITE</u> | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>MARRIED</u> | 8. DATE OF BIRTH <u>MAY 8, 1871</u> | 9. AGE (In years last birthday) <u>85</u> | IF UNDER 1 YEAR Months <u>1</u> Days <u>20</u> | IF UNDER 24 HRS. Hours <u></u> Min. <u></u> |
|--------------------|-------------------------------|-----------------------------------------------------------------------|-------------------------------------|-------------------------------------------|------------------------------------------------|---------------------------------------------|

|                                                                                                                      |                                                          |                                                                     |                                            |
|----------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------|---------------------------------------------------------------------|--------------------------------------------|
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RAILWAY ENGR. RET</u> | 10b. KIND OF BUSINESS OR INDUSTRY <u>FRISCO RAILROAD</u> | 11. BIRTHPLACE (State or foreign country) <u>MOBERLEY, MISSOURI</u> | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> |
|----------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------|---------------------------------------------------------------------|--------------------------------------------|

|                                      |                                               |                                                     |
|--------------------------------------|-----------------------------------------------|-----------------------------------------------------|
| 13a. FATHER'S NAME <u>JAMES RICE</u> | 13b. MOTHER'S MAIDEN NAME <u>SARAH PHIPPS</u> | 14. NAME OF HUSBAND OR WIFE <u>MAMIE CLARK RICE</u> |
|--------------------------------------|-----------------------------------------------|-----------------------------------------------------|

|                                                                                                                    |                                    |                                                                          |                 |
|--------------------------------------------------------------------------------------------------------------------|------------------------------------|--------------------------------------------------------------------------|-----------------|
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO</u> | 16. SOCIAL SECURITY NO. <u>UNK</u> | 17. INFORMANT'S SIGNATURE OR NAME <u>MAMIE CLARK RICE - CHAFFEE, MO.</u> | ADDRESS <u></u> |
|--------------------------------------------------------------------------------------------------------------------|------------------------------------|--------------------------------------------------------------------------|-----------------|

|                                                                                                                                                                                                                                 |                                                                                                                                                                                              |  |                                  |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------|
| 18. CAUSE OF DEATH<br>Enter only one cause per line for (a), (b), and (c)<br><br>*This does not mean the mode of dying, such as heart failure, asphyxia, etc. It means the disease, injury, or complication which caused death. | MEDICAL CERTIFICATION                                                                                                                                                                        |  | INTERVAL BETWEEN ONSET AND DEATH |
|                                                                                                                                                                                                                                 | I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Cerebral Hemorrhage</u>                                                                                                            |  | <u>7 da</u>                      |
|                                                                                                                                                                                                                                 | ANTECEDENT CAUSES<br>Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last...<br>DUE TO (b) <u>Cerebral Arteriosclerosis</u><br>DUE TO (c) <u></u> |  | <u>3 yr.</u>                     |
| II. OTHER SIGNIFICANT CONDITIONS<br>Conditions contributing to the death but not related to the disease or condition causing death.                                                                                             |                                                                                                                                                                                              |  |                                  |

|                        |                                  |             |                                                                                  |
|------------------------|----------------------------------|-------------|----------------------------------------------------------------------------------|
| 19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | <u>331X</u> | 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) m. | 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 6-21, 1956, to 6-28, 1956, that I last saw the deceased alive on 6-28, 1956, and that death occurred at 1:40P m., from the causes and on the date stated above.

|                                                           |                                       |                                 |
|-----------------------------------------------------------|---------------------------------------|---------------------------------|
| 23a. SIGNATURE (Degree or title) <u>Harold Bedding MD</u> | 23b. ADDRESS <u>Cape Girardeau Mo</u> | 23c. DATE SIGNED <u>7/29/56</u> |
|-----------------------------------------------------------|---------------------------------------|---------------------------------|

|                                                         |                               |                                                         |                                                                               |
|---------------------------------------------------------|-------------------------------|---------------------------------------------------------|-------------------------------------------------------------------------------|
| 24a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u> | 24b. DATE <u>July 1, 1956</u> | 24c. NAME OF CEMETERY OR CREMATORY <u>MEMORIAL PARK</u> | 24d. LOCATION (City, town, or county) (State) <u>CAPE GIRARDEAU, MISSOURI</u> |
|---------------------------------------------------------|-------------------------------|---------------------------------------------------------|-------------------------------------------------------------------------------|

|                                         |                                                     |                                                                   |                             |
|-----------------------------------------|-----------------------------------------------------|-------------------------------------------------------------------|-----------------------------|
| DATE REC'D BY LOCAL REG. <u>6-30-56</u> | REGISTRAR'S SIGNATURE <u>Elizabeth Summers, Dep</u> | 25. FUNERAL DIRECTOR'S SIGNATURE <u>BISPLINGHOFF FUNERAL HOME</u> | ADDRESS <u>CHAFFEE, MO.</u> |
|-----------------------------------------|-----------------------------------------------------|-------------------------------------------------------------------|-----------------------------|

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

JUL 10 1953

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

*Jack J. Burnett*

Licensed Embalmer No. *4473*

P. O. Address *C. Ruffee, Mo.*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.