

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **37127**

FILED DEC 3 1956

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. **42** PRIMARY REG. DIST. NO. **1000** Registrar's No. **1232**

1. PLACE OF DEATH a. COUNTY <b>Buchanan</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <b>Missouri</b> b. COUNTY <b>Buchanan</b>	
b. CITY (If outside corporate limits, write RURAL and give OR TOWN <b>St. Joseph</b> )	c. LENGTH OF STAY (In this place) <b>51 yrs</b>	c. CITY OR TOWN <b>St. Joseph</b>	d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>1323 South 22nd St.</b>		f. STREET ADDRESS (If rural, give location) <b>1323 South 22nd St.</b> <b>01170</b>	

3. NAME OF DECEASED (Type or Print)	a. (First) <b>LEONARD</b>	b. (Middle) <b>D.</b>	c. (Last) <b>RICE</b>	4. DATE OF DEATH (Month) (Day) (Year) <b>NOV. 15, 1956</b>
-------------------------------------	---------------------------	-----------------------	-----------------------	--

5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>married</b>	8. DATE OF BIRTH <b>June 11, 1891</b>	9. AGE (In years last birthday) <b>65</b>	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HRS. Hours _____ Min. _____
--------------------	-------------------------------	---	---------------------------------------	---	---	---

10a. USUAL OCCUPATION (Give kind of work depending most of working life, even if retired) <b>retired boilermaker</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>Schreiber Mills</b>	11. BIRTHPLACE (City and State or Foreign Country) <b>Creston, Iowa</b>	12. CITIZEN OF WHAT COUNTRY? <b>USA</b>
--	--	---	---

13a. FATHER'S NAME <b>James A. Rice</b>	13b. MOTHER'S MAIDEN NAME <b>Nellie Philpot</b>	14. NAME OF HUSBAND OR WIFE <b>Anna</b>
---	---	---

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>	16. SOCIAL SECURITY NO. <b>491-09-1838</b>	17. INFORMANT'S SIGNATURE OR NAME <b>Mrs. Anna Rice, 1323 So. 22 St., St. Jos., Mo.</b>	ADDRESS
---	--	---	---------

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)  <i>*This does not mean the mode of dying, such as heart failure, ashenia, etc. It means the disease, injury, or complication which caused death.</i>	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH <b>seconds</b>
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Coronary thrombosis</b>		
	ANTECEDENT CAUSES DUE TO (b) <b>Coronary sclerosis</b> _____ years DUE TO (c) <input checked="" type="checkbox"/> <b>Arteriosclerotic heart disease</b> _____ years Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <b>Calcific aortic stenosis</b>			

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? <b>420.0</b> 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)	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 **Sept 24, 1955**, to **Nov 15, 1956**, that I last saw the deceased alive on **Nov 15, 1956**, and that death occurred at **3:30A** m., from the causes and on the date stated above.

23a. SIGNATURE <b>Carol A. Sotter, M.D.</b>	(Degree or title)	23b. ADDRESS <b>301 Phy &amp; S urg Bldg., City</b>	23c. DATE SIGNED <b>11-16-56</b>
---	-------------------	---	----------------------------------

24a. BURIAL (CREMATION) REMOVAL (Specify)	24b. DATE <b>Nov 17, 1956</b>	24c. NAME OF CEMETERY OR CREMATORY <b>Mt. Olivet Cemetery</b>	24d. LOCATION (City, town, or county) (State) <b>St. Joseph, Missouri</b>
---	-------------------------------	---	---

DATE REC'D BY LOCAL REG. <b>Nov 26, 1956</b>	REGISTRAR'S SIGNATURE <b>Lothar M. Allison</b>	25 FUNERAL DIRECTOR'S SIGNATURE <b>Heaton Bowman</b>	ADDRESS <b>Dunbar Funeral Home, St. Joseph, Mo.</b>
--	--	--	---

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

1850

APR 3 1915

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.....  
Signature of Student Embalmer

Signed *William Spalding*.....  
Licensed Embalmer No. *4535*.....

P. O. Address *316 11th St. S. J. Minn.*.....

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.  
If this body is not embalmed, fact should be so stated above.