

Health,
& Welfare
Public
Service

FILED APR 16 1957

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

13371
STATE FILE NUMBER
1470

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 1470

S. 300
1-57

1. PLACE OF DEATH a. COUNTY Jackson			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Jackson		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Kansas City		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN Kansas City		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION St. Joseph Hospital		Length of stay in 1b 18 Yrs.	d. STREET ADDRESS (If outside, give location) 3927 Kenwood		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Ray Middle F. Last Rice			4. DATE OF DEATH Month 3 Day 27 Year 57		
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOW <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2-27-1900	9. AGE (In years last birthday) 57	10. F UNDER 1 YEAR Months 5 Days 1
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Butcher		10b. KIND OF BUSINESS OR INDUSTRY Packing House	11. BIRTHPLACE (City and state or country) Decuey Co., Okla.		12. CITIZEN OF WHAT COUNTRY? USA
13a. FATHER'S NAME John M. Rice		13b. MOTHER'S MAIDEN NAME M.J. Nedro		14. NAME OF HUSBAND OR WIFE Chlorse G. Rice	
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. 610-09-0271		17. INFORMANT Address Wife 3927 Kenwood KCMO.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Cardiac Failure					INTERVAL BETWEEN ONSET AND DEATH 5 minutes
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) Chronic Angiocardiosclerosis					
DUE TO (c) Leukemia					
PART II. OTHER SIGNIFICANT-CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) 2041					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> 2
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)		
20c. TIME OF INJURY Hour 11:30 A.M. Month, Day, Year					
20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION COUNTY STATE	
21. I attended the deceased from 3-15-57 to 3-29-57 and last saw ^{him} alive on 3-27-57 Death occurred at 11:30 A.M. m on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE John T. Skinner MD (Degree or title)			22b. ADDRESS 1102 Grand St. KCMO		22c. DATE SIGNED 3-29-57
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 3-30-57	23c. NAME OF CEMETERY OR CREMATORY Mt. Moriah		23d. LOCATION (City, town, or county) (State) Kansas City Mo.
24. FUNERAL DIRECTOR Melody-McGilley-Eylar ADDRESS KCMO.			25. DATE RECD. BY LOCAL REG. 3-29-57	26. REGISTRAR'S SIGNATURE Neer Minshall	

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE
MEDICAL CERTIFICATION
John T. Skinner

Dr. J. T. Skinner
Bryant Blvd.
Vic 2-7010

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2

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 *J. T. Skinner*
Licensed Embalmer No. *2994*
P. O. Address *EC*

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.