

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-029656

STATE FILE NUMBER

Registration District No. 200 Primary Registration District No. 4311 Registrar's No. 40

FILED AUG 19 1958

S. 300
1-57

1. PLACE OF DEATH a. COUNTY <u>Madison</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo</u> b. COUNTY <u>Madison</u>							
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Callao</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN <u>Callao 0610</u>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>					
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION			Length of stay in 1b		d. STREET ADDRESS (If outside, give location) <u>0</u>		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>				
3. NAME OF DECEASED (Type or print) First <u>Effie</u> Middle <u>Rice</u> Last <u>Rice</u>				4. DATE OF DEATH Month <u>7</u> Day <u>14</u> Year <u>58</u>							
5. SEX <u>Female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>2-1-78</u>		9. AGE (In years last birthday) <u>80</u>		IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u>		IF UNDER 24 HRS. Hours <u>0</u> Min. <u>0</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>domestic</u>			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) <u>Callao Mo</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>				
13a. FATHER'S NAME <u>Berry Rice</u>				13b. MOTHER'S MAIDEN NAME <u>Rebecca J. White</u>				14. NAME OF HUSBAND OR WIFE <u>Max Sumner</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.		17. INFORMANT <u>Max Sumner</u>		Address <u>Callao Mo</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u>								INTERVAL BETWEEN ONSET AND DEATH <u>18 hours</u>			
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.		DUE TO (b) <u>ARTERIO SCLEROSIS</u>		DUE TO (c) <u>4201</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
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 <u>3:30</u> Month <u>7</u> Day <u>12</u> Year <u>58</u> a.m. <u>AM</u> p.m.											
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 <u>7/12/58</u> to <u>7/14/58</u> and last saw ^{her} him alive on <u>7/14/58</u> Death occurred at <u>330 AM</u> on the date stated above; and to the best of my knowledge, from the causes stated.											
22a. SIGNATURE (Degree or title) <u>O.E. Sharp DO</u>				22b. ADDRESS <u>Callao Mo</u>				22c. DATE SIGNED <u>Aug 11, 58</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION (City, town, or county) (State)			
<u>Burial</u>		<u>7-16-58</u>		<u>Concord Cem</u>				<u>Callao Mo</u>			
24. FUNERAL DIRECTOR <u>W.S. Edwards</u>				ADDRESS <u>Concord Mo</u>		25. DATE RECD. BY LOCAL REG. <u>7/24/58</u>		26. REGISTRAR'S SIGNATURE <u>Mrs. Ruth McNeely</u>			

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

County File No. 1-38
Dues Paid 8-18-58

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 *H. Y. Edwards*

Licensed Embalmer No. 1961
P. O. Address *Berwick, 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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.