

Dr. Greene
MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-62-023965

Registration District No. 209 Primary Registration District No. 3043 Registrar's No. 237

STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. 209 Primary Registration District No. 3043 Registrar's No. 237
FILED JUL 13 1962

1. PLACE OF DEATH a. COUNTY <u>Marion</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Clinton</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Hannibal</u>		Length of stay in 1b	c. CITY OR TOWN <u>Cameron</u>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>St. Elizabeth Hospital</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <u>Nellie</u> Middle <u>A.</u> Last <u>Rice</u>			4. DATE OF DEATH Month <u>J</u> Day <u>une</u> Year <u>1962</u>	
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5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov. 8, 1898</u>	9. AGE (last birthday) <u>63</u>	IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	IF UNDER 24 HR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Telephone Operator-Retired</u>	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) <u>Missouri</u>	12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>
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13a. FATHER'S NAME <u>John Rice</u>	13b. MOTHER'S MAIDEN NAME <u>Mary Kenney</u>	14. NAME OF HUSBAND OR WIFE <u>---</u>
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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) <u>NO</u>	16. SOCIAL SECURITY NO.	17. INFORMANT <u>Mr. Cyril Rice, Cameron, Mo.</u>	Address
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a) <u>Uremia</u>		<u>1 week</u>
DUE TO (b) <u>Arteriosclerotic nephritis</u>		<u>1 week</u>
DUE TO (c)		

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Central Arterial Thrombosis</u>	PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown
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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.)
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20c. TIME OF INJURY Hour <u> </u> s.m. <u> </u> p.m. <u> </u>	Month, Day, Year
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20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE 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
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21. I attended the deceased from _____ to _____ and last saw her/him alive on _____
 Death occurred at 3:02 A.M. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <u>E.H. Seaman M.D.</u> (Degree or title)	22b. ADDRESS <u>1007 6th Hannibal</u>	22c. DATE SIGNED <u>6/29/1962</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	23b. DATE <u>June 29, 1962</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Kenney Cemetery</u>	23d. LOCATION (City, town, or county) (State) <u>E. Cameron, Missouri</u>
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24. FUNERAL DIRECTOR <u>H.M.O'Donnell, Hannibal, Mo.</u>	25. DATE RECD. BY LOCAL REG. <u>June 29, 1962</u>	26. REGISTRAR'S SIGNATURE <u>Dr. E.M. Lucke by Lillian M. Herman</u>
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(Licensed Embalmer's Statement on Reverse Side)

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Rev. 4/59

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS
 INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

USE BLACK INK
OR
TYPEWRITER RIBBON

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 *Wm O'Donnell*

Licensed Embalmer No. 3889

P. O. Address Hannibal, 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.

Permit revised 4/29/62