

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-63-013746

DO NOT WRITE  
ON THIS STUB

AMENDED

Registration District No. **318**

318

Primary Registration District No. **1003**

1003

Registrar's No. **3582**

3582

STATE FILE NUMBER

FILED APR 8 1963

1. PLACE OF DEATH a. COUNTY		b. CITY (if outside corporate limits, give TOWNSHIP only) OR TOWN		Length of stay in 1b	2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE		b. COUNTY		
		ST. LOUIS, MISSOURI			Missouri		COUNTY		
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION		Inside Limits Yes <input 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"/>			
		BARNES HOSPITAL		3237 Harper St.					
3. NAME OF DECEASED (Type or print)			First	Middle	Last	4. DATE OF DEATH			
			GOLDEN	C.	RICE	Month	Day	Year	
						MARCH	27	1963	
5. SEX	6. COLOR OR RACE	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH		9. AGE (last birthday)		IF UNDER 1 YEAR	IF UNDER 24 HR
Female	White			6/1/99		63yrs.		Months	Days
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country)		12. CITIZEN OF WHAT COUNTRY		Hours	Min.
Bookkeeper		Orphanage		Girard Illinois		U.S.			
13a. FATHER'S NAME			13b. MOTHER'S MAIDEN NAME			14. NAME OF HUSBAND OR WIFE			
Fisher A. Rice			Sadie Ann Kaiser			never married			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.			17. INFORMANT			
no						5820 N. Rural Indianapolis Ind.			
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)								10 da.	
PNEUMONIA, TYPE UNDETERMINED									
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.								6 years	
DUE TO (b)									
IDIOPATHIC PULMONARY FIBROSIS									
DUE TO (c)									
525X									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)						PART III. If deceased was female was there a pregnancy in last 90 days			
ARTERIOSCLEROTIC HEART DISEASE						<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input 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 a.m. p.m.		Month, Day, Year					
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	
21. I attended the deceased from <u>5/12/56</u> to <u>3/27/63</u> and last saw her/him alive on <u>3/27/63</u> . Death occurred at <u>7:40 a.m.</u> m. on the date stated above, and to the best of my knowledge, from the causes stated.									
22a. SIGNATURE (Degree or title)					22b. ADDRESS			22c. DATE SIGNED	
<i>C. J. Vannelli, M.D.</i>					M.D.			BARNES HOSPITAL	
								3/27/63	
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town, or county) (State)			
Removal		3/29/63		Girard Cemetery		Girard Illinois			
24. FUNERAL DIRECTOR			ADDRESS			25. DATE RECD. BY LOCAL REG.		26. REGISTRAR'S SIGNATURE	
Morrell			3710 N. Grand Blvd.			MAR 28 1963		<i>Earl Smith, M.D.</i>	

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

VS 300  
Rev. 4/59

1

2 **210**

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5 **0**

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7 **1**

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10

11

12 **52-0**

13

**52**

**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 Loren E. Percy

Licensed Embalmer No. 4094

P. O. Address St. Louis, 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.