

**MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH**

Do not use this space.

19144

1. PLACE OF DEATH

County Way
Township Richmond
City Richmond (No. _____)

Registration District No. 744
Primary Registration District No. 3033

File No. _____
Registered No. 45
St. _____ Ward _____

2. FULL NAME

John Davis Vincil Kice

(a) Residence No. _____ St. _____ Ward _____
(Usual place of abode) (If nonresident, give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Man 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Married

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Marie Kice

6. DATE OF BIRTH (MONTH, DAY AND YEAR) 1 / 1

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, _____ hrs. or _____ min.
60 1 28

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Dentist
(b) General nature of industry, business, or establishment in which employed (or employer) _____
(c) Name of employer _____

9. BIRTHPLACE (CITY OR TOWN) Richmond
(STATE OR COUNTRY) Way - Mo.

10. NAME OF FATHER R B Kice

11. BIRTHPLACE OF FATHER (CITY OR TOWN) Lexington
(STATE OR COUNTRY) Mo.

12. MAIDEN NAME OF MOTHER Joella Jackson

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Richmond
(STATE OR COUNTRY) Mo.

14. INFORMANT Marie Kice
(Address) Richmond

15. FILED May 25, 1929 6 6. Jay REGISTRAR

2 MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) May 23 1929
17. _____

I HEREBY CERTIFY, That I attended deceased from May 23, 1929, to May 23, 1929, and that I last saw him alive on May 23, 1929, and that death occurred, on the date stated above, at 9:15 p. m.

93c THE CAUSE OF DEATH* WAS AS FOLLOWS:
Acute Dilatation of heart due to Myocardial degeneration
(duration) _____ yrs. _____ mos. _____ ds.

CONTRIBUTORY (SECONDARY) Chronic Myocarditis
(duration) Several years

18. WHERE WAS DISEASE CONTRACTED
Home
(NOT AT PLACE OF DEATH)

19. DID AN OPERATION PRECEDE DEATH. No DATE OF _____

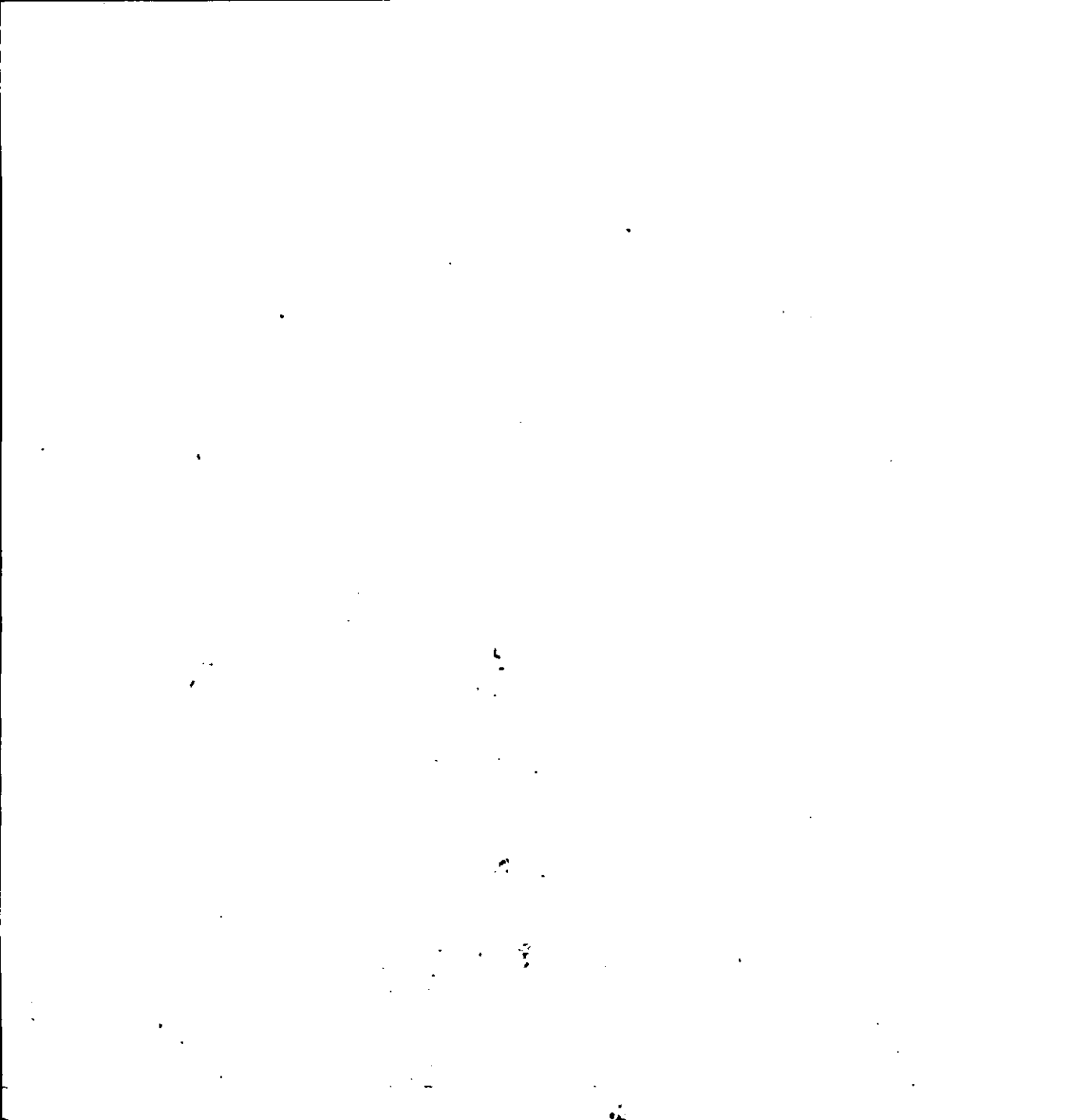
20. WAS THERE AN AUTOPSY? No
WHAT TEST CONFIRMED DIAGNOSIS? Clinical
(Signed) 6 6. Jay, M. D.
19 Richmond Mo. (Address)

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) Whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL City Cemetery DATE OF BURIAL May 25 1929

20. UNDERTAKER E J Thurman ADDRESS Richmond

PARENTS



**MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH**

ALL INFORMATION CALLED
FOR MUST BE WRITTEN ON
THIS SUPPLEMENTARY.

1. PLACE OF DEATH

County Ray Registration District No. 944 File No. _____
 Township _____ Primary Registration District No. 3093 Registered No. 45-
 City Richmond (No. _____) St. _____ Ward _____

2. FULL NAME

John Davis V. Rice
 (a) Residence No. _____ St. _____ Ward _____
 (Usual place of abode) (If nonresident, give city or town and State)
 Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) M

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF _____

6. DATE OF BIRTH (MONTH, DAY AND YEAR) March 25-1869

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
60 1 28

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work _____ (duration) yrs. mos. ds.
 (b) General nature of industry, business, or establishment in which employed (or employer) _____
 (c) Name of employer _____

9. BIRTHPLACE (CITY OR TOWN) _____ (STATE OR COUNTRY) _____

10. NAME OF FATHER _____

11. BIRTHPLACE OF FATHER (CITY OR TOWN) _____ (STATE OR COUNTRY) _____

12. MAIDEN NAME OF MOTHER _____

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) _____ (STATE OR COUNTRY) _____

14. INFORMANT _____ (Address) _____

15. FILED May 25 1929 E. B. Gray REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) May 23 1929

17. I HEREBY CERTIFY That I attended deceased from _____, 19____ to _____, 19____ that I last saw h. _____ alive on _____, 19____, and that death occurred, on the date stated above, at _____ m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

CONTRIBUTORY (SECONDARY) _____ (duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED _____

IF NOT AT PLACE OF DEATH _____

DID AN OPERATION PRECEDE DEATH? _____ DATE OF _____

WAS THERE AN AUTOPSY? _____

WHAT TEST CONFIRMED DIAGNOSIS? _____

(Signed) _____, M. D.

, 19____ (Address) _____

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) Whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL _____ DATE OF BURIAL _____

20. UNDERTAKER _____ ADDRESS _____

SUPPLEMENTARY

5-19144