WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

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

1 PLACE OF DEATH

County Jasper

Township or Village

Registration District No. 417 File No. 29704

Primary Registration District No. 3071 Registered No. 185

or City Webb City Jasper Co Tuberculosis Hospital (No. St. Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME Oscar Rhodes.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male

4 COLOR OR RACE White

5 SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word) Married

6 DATE OF BIRTH Nov (Month) 17 (Day), 1882 (Year)

7 AGE 35 yrs. 9 mos. 5 ds. If LESS than 1 day, ...hrs. or ....min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work Miner
(b) General nature of industry business, or establishment in which employed (or employer)

9 BIRTHPLACE (City or town, State or foreign country) Rolls Co Mo.

PARENTS

10 NAME OF FATHER Jeff Rhoades

11 BIRTHPLACE OF FATHER (City or town, State or foreign country) Mo

12 MAIDEN NAME OF MOTHER Thelia Utterbacks

13 BIRTHPLACE OF MOTHER (City or town, State or foreign country) Mo

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Jeffred Rhoades
(Address) Webb City Mo.

15 Filed Sept. 24th 1918 C. E. McBride Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Sept (Month) 22 (Day), 1918 (Year)

17 I HEREBY CERTIFY, that I attended deceased from Sept 13, 1918, to Sept 22, 1918, that I last saw him alive on Sept 22, 1918, and that death occurred, on the date stated above, at 9.40 a m.

The CAUSE OF DEATH* was as follows:

28

Pulmonary Tuberculosis

23 A

(Duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) Leo Stock M. D.

Sept 22, 1918 (Address) Webb City Mo

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death ....yrs. ....mos. 10 ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted if not at place of death? unknown

Former or usual residence Carterville Mo.

19 PLACE OF BURIAL OR REMOVAL Mt. Hope Cem DATE OF BURIAL Sept 24, 1918

20 UNDERTAKER Webb City Mnd Co ADDRESS Webb City

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

1 PLACE OF DEATH

County .....

Township ..... Registration District No. ..... File No. .....
or
Village ..... Primary Registration District No. ..... Registered No. .....
or
City ..... (NO. ....., ... St. ..... Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME .....

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 SINGLE MARRIED WIDOWED OR DIVORCED (*Write* the word)

6 DATE OF BIRTH

..... (Month) ....., 1..... (Year) (Day)

7 AGE ..... yrs. ..... mos. ..... ds.

If LESS than 1 day, ... hrs. or ..... min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work .....

(b) General nature of industry business or establishment in which employed (or employer) .....

9 BIRTHPLACE
(City or town, State or foreign country)

PARENTS

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER
(City or town, State or foreign country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER
(City or town, State or foreign country)

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) .....

(Address) .....

15

Filed ....., 191....., ...
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

..... (Month) ....., 191..... (Day) (Year)

17 I HEREBY CERTIFY, that I attended deceased from

....., 191....., to ....., 191.....,

that I last saw h..... alive on ....., 191.....,

and that death occurred, on the date stated above, at ..... m.

The CAUSE OF DEATH* was as follows:

.....

.....

.....

..... (Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY .....
(Secondary)

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) ..... M. D.

....., 191..... (Address) .....

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL ....., 191.....
20 UNDERTAKER	ADDRESS

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.