MAR 21 1928

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

Do not use this space.

7567

1. PLACE OF DEATH

County Wayne — Registration District No. 890 — File No.

Township — Primary Registration District No. 4539 — Registered No.

City Greenville (No. ..... St. ..... Ward)

2. FULL NAME Emaline M. Rhodes

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

Length of residence in city or town where death occurred 35 yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

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

5A. ~~IF MARRIED, WIDOWED, OR DIVORCED~~ ~~HUSBAND OF~~ (OR) WIFE OF David F Rhodes

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Oct 11 1843

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, ... hrs. or ..... min.
	84	4	3	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work none

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

(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) Madison Co Mo
(STATE OR COUNTRY) Mo

PARENTS

10. NAME OF FATHER Wm Halladay

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

12. MAIDEN NAME OF MOTHER Jane W Tong

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

14. INFORMANT Wm A Little
(Address) Greenville Mo

15. FILED 2-16 1928 Geo T Leeper REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 2-14-1928

17. I HEREBY CERTIFY, That I attended deceased from 2-5-1928, 19.., to 2-14-1928, that I last saw h.. alive on 2-13-1928, and that death occurred, on the date stated above, at 12:25 p.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Acute Intestinal Obstruction
92A
122B
(duration) ..... yrs. ..... mos. 9 ds.

CONTRIBUTORY (SECONDARY) Chronic Endo Carditis
(duration) 8 yrs. ..... mos. ..... ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH? —

O DID AN OPERATION PRECEDE DEATH? No. DATE OF —

WAS THERE AN AUTOPSY? no —

WHAT TEST CONFIRMED DIAGNOSIS? —

(Signed) Jno F Wagner, M. D

2-15, 1928 (Address) Greenville Mo

*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
Union Cem	2-15-1928

20. UNDERTAKER	ADDRESS
F C Yates	Piedmont Mo

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

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

1. PLACE OF DEATH.

County Wayne — Registration District No. 890 — File No. .....

Township ..... — Primary Registration District No. 4539 — Registered No. .....

City Greenville (No. ....., ... St. ..... Ward)

2. FULL NAME Emaline M Rhodes

(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: F
4. COLOR OR RACE: W
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (*write* the word): W

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Oct 11-1843

7. AGE

YEARS	MONTHS	DAYS	If LESS than 1 day, ... hrs. or ..... min.
84	4	3	

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

PARENTS

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 2/16 1928 Geo T Lupus
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 2-14 1928

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

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Acute Intestinal obstruction
Dont Know Cause
(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (SECONDARY) .....
118 B 2
(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) Geo F Wagner, 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 19

20. UNDERTAKER — ADDRESS

SUPPLEMENTARY

N. B. ... AGE should be stated EXACTLY. PHY... d state
CAU... th... m... ly classif... Exact statement of OCCUPATION ... important.
REGIS... AFS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW

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