

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

Do not use this space.

17179

1. PLACE OF DEATH

County.....*Jackson*..... Registration District No.....*399*..... File No.....
Township.....*Rau*..... Primary Registration District No.....*1093*..... Registered No.....
City.....*Kansas City*..... (No. *Kansas City General Hospital* St. Ward)

2. FULL NAME

Mrs. Bertha Opal Rhoades
(a) Residence. No.....*H 235 Baker*..... St. Ward.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred *2* yrs. mos. da. How long in U.S., if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX *Female* 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 *Oral Samuel Rhoades*

6. DATE OF BIRTH (MONTH, DAY AND YEAR) *Mar 6 - 1904*

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, hrs. or min.
	<i>24</i>	<i>2</i>	<i>9</i>	

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

9. BIRTHPLACE (CITY OR TOWN) *Linn Creek Mo.*
(STATE OR COUNTRY)

10. NAME OF FATHER *Andrew Boiv*

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

12. MAIDEN NAME OF MOTHER *Mollie Hasting*

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

14. INFORMANT *Shes J. Rhoades*
(Address) *Wakenda Ave*

15. *May 15, 1928* M. M. Crowe
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

2 **Tuesday**
16. DATE OF DEATH (MONTH, DAY AND YEAR) *May 15 1928*

17. *Stylyt Corner*
I HEREBY CERTIFY, That I attended deceased from 19....., to 19....., and that I last saw h..... alive on 19....., and that death occurred, on the date stated above, at..... *6:50 a.m.*

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Septic Pneumonia
138
CONTRIBUTOR (SECONDARY) *Battered 40-year old*
Not Puerperal or Posturhead

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH.....

19. DID AN OPERATION PRECEDE DEATH? *No* DATE OF.....
WAS THERE AN AUTOPSY? *yes*

WHAT TEST CONFIRMED DIAGNOSIS? *autopsy*
(Signed) *Paul J. ...* M. D.
715, 1928 (Address) *Stylyt Corner*

*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 *Brooking Cemetery* DATE OF BURIAL *May 17 1928*

20. UNDERTAKER *Cylar Funeral Home* ADDRESS *1800 Linwood*

K. 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—THIS IS A PERMANENT RECORD

