

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

Do not use this space.

43198

1. PLACE OF DEATH

County Sullivan
Township Ruehanna
City (No.) (No.)

Registration District No. 858
Primary Registration District No. 6129

File No. 8
Registered No. 28
St. Ward)

2. FULL NAME

Carroll Lee Rhoades

(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 male 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Dec. 8, 1929

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, hrs. or min.
			<u>6</u>	

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) Mo

10. NAME OF FATHER

Theodore Rhoades

11. BIRTHPLACE OF FATHER (CITY OR TOWN)

(STATE OR COUNTRY) Mo

12. MAIDEN NAME OF MOTHER

Ada Warren

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)

(STATE OR COUNTRY) Mo

14.

INFORMANT Theo. Rhoades
(Address) Green City Mo

15.

FILED 12/30, 1929 Thos. Parsons
REGISTRAR

2 MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Dec-14-1929

17. I HEREBY CERTIFY, That I attended deceased from Dec 14, 1929, to Dec 14, 1929 that I last saw him alive on Dec 14, 1929, and that death occurred, on the date stated above, at m.

THE CAUSE OF DEATH WAS AS FOLLOWS:

Suppression of urine
130
130C

(duration) yrs. mos. ds.
CONTRIBUTORY (SECONDARY) traumatic poisoning
(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) W. L. Taylor M. D.

12/14, 1929 (Address) Green City 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

Mt. Olivet Cem Dec 15 1929

20. UNDERTAKER

ADDRESS

Glenn E Kent Green City Mo

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.

1929
1930

