

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

Do not use this space.

Dr. Arthur Knapp
12357

1. PLACE OF DEATH

County Greene Registration District No. 318
Township W. 1st Primary Registration District No. 5439
City Springfield, Mo. No. 15

File No. _____
Registered No. 332
St. _____ Ward)

2. FULL NAME

Mary Raymond Rhodes
(a) Residence. No. R 20 # 5 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) married

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Aug 1 1899

7. AGE YEARS MONTHS DAYS If LESS than 1 day,hra. ormin.
30 8 13

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

10. NAME OF FATHER Chas. Owens

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

12. MAIDEN NAME OF MOTHER Myrtle L.

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

14. INFORMANT (Address) Max Pleas Owens
R. 20 # 5

15. FILED 4-27-35 For Sharp REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 4/25th 1930

17. I HEREBY CERTIFY, That I attended deceased from April 5, 1930, to April 24th 1930, that I last saw her alive on April 19, 1930, and that death occurred, on the date stated above, at 6 a m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Pulmonary Tuberculosis
23A
(duration) yrs. 6 mos. ds.

CONTRIBUTORY (SECONDARY) 37
(duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED
IF 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) Arthur Knapp M.D.
4-26-30 (Address) 450 1/2 E. Conil

*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 St. Marys Ch. DATE OF BURIAL 4-30-1930

20. UNDERTAKER Sherman L. Loney, Jr. Mo. ADDRESS _____

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.

WRITE HEREIN WITH UNFADING INK—THIS IS A PERMANENT RECORD

MAY 26 1930

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