

1939 APR 11 10:06

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

10774
Do not use this space.

1. PLACE OF DEATH

(a) County Gentry Registration District No. 313
 (b) Township McFall, Mo. Primary Registration District No. 4189 Registered No. 17
 (c) City McFall, Mo. (d) Street No. _____ St.
 (If death occurred in Hospital or Institution, write its name instead of street and number)
 (e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME 371 Ruby Lois Rhodes

(a) Residence, No. _____ St. (If nonresident, give city or town and State)
 (Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX F 4. COLOR OR RACE W 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) 3/14/30 32

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, _____ hrs. or _____ min.
7 X I3

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. _____
 9. Industry or business in which work was done, as saw mill, bank, etc. Student
 10. Date deceased last worked at this occupation (month and year) _____ 11. Total time (years) spent in this occupation _____

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Mo

FATHER 13. NAME Samuel Frank Rhodes

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Mo

MOTHER 15. MAIDEN NAME Ivaree Brinnen

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Mo

17. INFORMANT Frank Rhodes (ADDRESS) McFall, Mo.

18. BURIAL, CREMATION, OR REMOVAL PLACE Mc Fall, Mo. DATE 3/15/39

19. FUNERAL DIRECTOR (NAME) G. S. Gromer (ADDRESS) Pattonburg, Mo.

20. FILED 3/16/39, 19. N. W. Mothehead Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 3/14/39, 19--

22. I HEREBY CERTIFY, That I attended deceased from after death, 19--

I last saw h. _____ alive on _____, 19-- Death is said to have occurred on the date stated above, at 8 P. m.

The principal cause of death and related causes of importance were as follows:

Pneumonia
Complicating malnutrition

Date of onset _____

Other contributory causes of importance:

Name of operation _____ Date of _____

What test confirmed diagnosis? _____ Was there an autopsy? no

23. If death was due to external causes (violence), fill in also the following: Accident, suicide, or homicide? _____ Date of injury _____, 19--

Where did injury occur? _____ (Specify city or town, county, and State)
 Specify whether injury occurred in industry, in home, or in public place.

Manner of injury _____

Nature of injury _____

24. Was disease or injury in any way related to occupation of deceased? _____

If so, specify _____ (Signed) Dr. Frank A. Parsons M. D.

(Address) Pattonburg, Mo.
Coroner

Every record of information should be carefully supervised. A correct statement of OCCUPATION is very important. Exact statement of OCCUPATION is very important.

109

REL. 102-1
District Health Officer No. 11,
District File Number 39-230
Date Filed APR 7 1939

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,

....., or by

Registered Apprentice No....., working under my personal supervision.

Signed *G. Schomer*

Licensed Embalmer No. 2857

P. O. Address Pattonsburg, Mo.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, above space should be left blank.

FILL IN ANSWERS TO ALL SPACES
CHECKED IN RED PENCIL.

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

10774
Do not use this space.

1. PLACE OF DEATH

(a) County Centry Registration District No. 313
 (b) Township Primary Registration District No. 4189 Registered No. 17
 (c) City Mc Fall (d) Street No.
 (If death occurred in Hospital or Institution, write its name instead of street and number)
 (e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U.S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME Ruby Lois Rhodes

(a) Residence, No. St. (If nonresident, give city or town and State)
 (Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX 7 4. COLOR OR RACE W 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)
 7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
7 - 13
 OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc.
 9. Industry or business in which work was done, as saw mill, bank, etc.
 10. Date deceased last worked at this occupation (month and year)
 11. Total time (years) spent in this occupation

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

FATHER 13. NAME

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

MOTHER 15. MAIDEN NAME

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

17. INFORMANT (ADDRESS)

18. BURIAL, CREMATION, OR REMOVAL

PLACE DATE 19

19. FUNERAL DIRECTOR (ADDRESS)

20. FILED 19

Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 3-14 1938

22. I HEREBY CERTIFY, That I attended deceased from

I last saw h. alive on 3-14, 1938. Death is said

to have occurred on the date stated above, at Mc Fall, Mo.

The principal cause of death and related causes of importance were as follows:

Pneumonia
Complicating malnutrition
and possible influenza

Other contributory causes of importance:

Name of operation Date of

What test confirmed diagnosis? Was there an autopsy?

23. If death was due to external causes (violence), fill in also the following:

Accident, suicide, or homicide? Date of injury 19

Where did injury occur? (Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place.

Manner of injury

Nature of injury

24. Was disease or injury in any way related to occupation of deceased?

If so, specify

(Signed) Zeck A. Barnes, M.D.

(Address) Spring City, Mo.

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATE UNTIL TWELVE ARE COMPLETED AS PRESCRIBED BY MOORE

SUPPLEMENT

MAY - 3 1939