

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 29197

Registration District No. 14

Primary Registration District No. 5447-B

Registrar's No. 17

1. PLACE OF DEATH:

(a) County Greene
(b) City or town Stratford Mo.
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Yakovlev's
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether
In this community _____ years, months or days) 37

3. (a) PRINT FULL NAME Victorine Mitchell Rhodes

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced _____

6. (b) Name of husband or wife Robert E. Rhodes 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased: Unknown
(Month) (Day) (Year)

8. AGE: Years 70 Months _____ Days _____ If less than one day _____ min.

9. Birthplace: _____ (City, town, or county) (State or foreign country) Mo.

10. Usual occupation Housewife

11. Industry or business In home

12. Name N. L. Mitchell

13. Birthplace Ky. (City, town, or county) (State or foreign country)

14. Maiden name Minerva Waggoner

15. Birthplace S. Car (City, town, or county) (State or foreign country)

16. (a) Informant's own signature N. E. Rhodes

(b) Address Stratford Mo.

17. (a) Burial (b) Date thereof 8-23-1939
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation mt Pisgah

18. (a) Signature of funeral director W. H. Higgins

(b) Address 424 E. Commercial

19. (a) Aug 22 1939 (b) Haus Guier
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County Greene
(c) City or town Stratford
(If outside city or town limits, write "RURAL")
(d) Street No. _____ (If rural, give location)
(e) If foreign born, how long in U. S. A.? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug day 21st
year 1939 hour 10¹⁵ minute P M.

21. I hereby certify that I attended the deceased from Aug 20, 1939 to Aug 20, 1939 that I last saw him sh alive on Aug 20, 1939 and that death occurred on the date and hour stated above.

Immediate cause of death: Myocardial degeneration
Duration _____

Due to _____

Due to 430

Other conditions: _____ (Include pregnancy within 3 months of death)

Major findings: _____ Of operations _____

Of autopsy None

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) _____

(b) Date of occurrence _____

(c) Where did injury occur? _____ (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

(Specify type of place) _____ (While at work? _____) (Manner of injury)

23. Signature R. H. Ficht (M. D. or other) _____

Address Stratford Mo. Date signed _____

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.

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 Gale Stone Jr., Registered Apprentice No. 232 working under my personal supervision.

Signed Warren D. Roblett
Licensed Embalmer No. 4005
P. O. Address Springfield, 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.