

FILED MAR 12 1940

State File No. _____

Registration District No. 319

Primary Registration District No. 8439

Registrar's No. 130

1. PLACE OF DEATH:
(a) County Springfield
(b) City or town Springfield
(c) Name of hospital or institution: R#4
(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

2. USUAL RESIDENCE OF DECEASED:
(a) State Mo. (b) County Greene
(c) City or town Springfield
(If outside city or town limit, write "RURAL") R#4
(d) Street No. _____
(If rural, give location)
(e) If foreign born, how long in U. S. A? _____ years

3. (a) PRINT FULL NAME ROBERT E. RHODES

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

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

6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if _____

7. Birth date of deceased April 28 1850
(Month) (Day) (Year)

8. AGE: Years 89 Months 9 Days 10 If less than one day _____
Sr. min.

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

10. Usual occupation Retired merchant

11. Industry or business merchant

12. Name unknown

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

14. Maiden name unknown

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

16. (a) Informant Nash B. Mitchell

(b) Address Springfield, Mo.

17. (a) Burial (b) Date thereof Feb 11 - 1940
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Mt Pisgah

18. (a) Signature of funeral director [Signature]

(b) Address Springfield, Mo. 290

19. (a) 2/10/40 (b) Chas. A. [Signature]
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month Feb day 8
year 1940 hour 1 minute 40 A. M.

21. I hereby certify that I attended the deceased from 2,4,40, 19____, to 2,8,40, 19____;
that I last saw him alive on 2,7,40, 19____;
and that death occurred on the date and hour stated above.

Immediate cause of death: Pneumonia, Lobar

Due to _____

Due to _____

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

Major findings: Of operations _____

Of autopsy _____

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? _____

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

23. Signature [Signature] (M. D. or other) _____
Address Springfield, Mo. Date signed 2,8,40

Duration 4 days
PHYSICIAN _____
Underline the cause to which death should be charged statistically.

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

MOTHER FATHER

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

J. B. Klingner

Licensed Embalmer No. *3358*

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.

X