

MISSOURI STATE BOARD OF HEALTH
 STANDARD CERTIFICATE OF DEATH
 1003

State File No. 9384
 Registrar's No. 2867

Registration District No. 791

Primary Registration District No. _____

1. PLACE OF DEATH:

(a) County _____
 (b) City or town St. Louis, Mo.
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution:
St. Louis Children's Hosp.
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution 8 MRS.
 (Specify whether _____)
 In this community Never
 years, months or days

3. (a) PRINT FULL NAME Rhoades, Dale Bruce

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

4. Sex M 5. Color or race W 6. (a) Single, widowed, married, divorced child

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

7. Birth date of deceased 12-15-29
 (Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
10 3 10 hr. min.

9. Birthplace Illinois!
 (City, town, or county) (State or foreign country)

10. Usual occupation child

11. Industry or business _____

12. Name William M.

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

14. Maiden name Marlene Karrick

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

16. (a) Informant's own signature W. H. Hoppe

(b) Address 416 S. Kingshighway

17. (a) REMOVAL (b) Date thereof 3-28-40
 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation BUTLER, ILL.

18. (a) Signature of funeral director ALBERT H. HOPPE

(b) Address 4700 WASHINGTON AVE.

19. (a) MAR 27 1940 (b) _____
 (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Illinois (b) County Montgomery
 (c) City or town Butler NR
 (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 3 day 25
 year 40 hour 10 minute 40 P. M.

21. I hereby certify that I attended the deceased from 3-25
 _____, 1940, to 3-25 _____, 1940;
 that I last saw him alive on 3-25 _____, 1940;
 and that death occurred on the date and hour stated above.

Immediate cause of death Respiratory failure + obstruction - 10 hrs

Due to Leukemia, acute - 3 mo

Due to _____

Other conditions None
 (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 J. J. Deyoung (M. D. or other) M.D.

Address 500 So Kingshighway Date signed 3/25

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE 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.

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..... *Guy W Wilkinon*

Licensed Embalmer No..... *3575*

P. O. Address.....

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.