

No. 2
-10-39
17-39
X21492

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

27755

State File No. _____

Registration District No. 399

Primary Registration District No. 1002

Registrar's No. 3389

1. PLACE OF DEATH:

(a) County Jackson
(b) City or town Kansas City
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: K.C. General Hospital No. 1
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 19 days (Specify whether
In this community Life
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson
(c) City or town Kansas City
(If outside city or town limit, write "RURAL")
(d) Street No. 523 Grand Avenue
(If rural, give location)
(e) If foreign born, how long in U. S. A. ? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug. day 25th
1940 year hour 10 minute 32 A. M.

21. I hereby certify that I attended the deceased from Aug. 6th, 1940, to Aug. 25th, 1940, 19____;
what I last saw him alive on Aug. 25th, 1940, 19____;
and that death occurred on the date and hour stated above.

Immediate cause of death Hypertensive heart disease
Due to _____
Due to _____

Other conditions Terminal Bronchopneumonia;
Pulmonary infarction; encephalomalacia.

Major findings:
Of operations _____
Of autopsy See above

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 Dwight R. Thorn (M. D. or other)
Address Med. Dir. K. C. Gen. Hosp., K. C., Mo.

Duration
PHYSICIAN
98B
Underline the cause to which death should be charged statistically.

8. (a) PRINT FULL NAME THOMAS RHODES 320
8. (b) If veteran, _____ name war _____ 3. (c) Social Security No. 432-03-3439

4. Sex m 5. Color or race w
6. (a) Single, widowed, married, divorced. widow
6. (c) Age of husband or wife if alive. _____ years
7. Birth date of deceased: Feb 26, 1880
(Month) (Day) (Year)

8. AGE: Years 60 Months 5 Days 29 If less than one day _____ hr. _____ min.

9. Birthplace Nevada (City, town, or county) IND (State or foreign country)
10. Usual occupation Railroad Mechanic

11. Industry or business _____
12. Name Wm. A. Rhodes
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 Thomas Rhodes Jr.
(b) Address 1441 So 26th St. P.K.
17. (a) Burial (b) Date thereof 8-30-40
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation St. North Tex
18. (a) Signature of funeral director H. Zimmerman
(b) Address 2501 W. 1st
19. (a) Aug. 28, 1940 (b) M. D. Crowe
(Date received local registrar) (Registrar's signature)

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

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.....

Francis Walton....., Registered Apprentice No. *2744*
working under my personal supervision.

Signed *Francis Walton*
J. H. Doyin
Licensed Embalmer No. *2744*
P. O. Address *A.P. Ind*

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.