

FILED SEP 25 1940

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 29520

Registration District No. 273

Primary Registration District No. 4464

Registrar's No. 140

1. PLACE OF DEATH:

(a) County St. Francois
(b) City or town Farmington
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: 2
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 1 year (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County St. Francois
(c) City or town Farmington
(If outside city or town limits, write "RURAL")
(d) Street No. N. Washington
(If rural, give location)
(e) If foreign born, how long in U. S. A. _____ years.

3. (a) PRINT FULL NAME William Charles Rhodes 221

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 Single

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

7. Birth date of deceased April 2 1939
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
1 4 1 hr. _____ min.

9. Birthplace Farmington Missouri
(City, town, or county) (State or foreign country)

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER { 12. Name Marion Rhodes
13. Birthplace Flat River Missouri
(City, town, or county) (State or foreign country)

{ 14. Maiden name Elizabeth Barron
15. Birthplace Coffman Missouri
(City, town, or county) (State or foreign country)

16. (a) Informant Marion Rhodes
(b) Address Farmington Missouri

17. (a) Burial (b) Date thereof Aug. 4 1940
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Pleasant Hill Cemetery

18. (a) Signature of funeral director Richardson General Home
(b) Address 303 W. Columbia Farmington

19. (a) Aug 3-1940 (b) T. L. Robertson
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month August day 3 year 1940 hour 9 minute 15 M.

21. I hereby certify that I attended the deceased from Aug 1-4 1940 that I last seen alive on Aug 2 1940 and that death occurred on the date and hour stated above.

Immediate cause of death Infectious mononucleosis

Due to (Summer Complaint)

Due to _____
Other conditions (Include pregnancy within 3 months of death) 11/4/40

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? L.G.H.

(Specify type of place) While at work _____ (e) Means of injury _____
23. Signature [Signature] (M.D. or other) 1/22
Address Farmington Date signed 8-3-40

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

Signed

Paul K. Bungal

Licensed Embalmer No.

4120

P. O. Address

Farmington, 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.