

**NOV 22 1940**  
Registration District No. **342**

Primary Registration District No. **1002**

Registrar's No. **4058**

**1. PLACE OF DEATH:**  
(a) County Jackson  
(b) City or town Kansas City  
(c) Name of hospital or institution: General Hospital #2  
(d) Length of stay: In hospital or institution 9-22-40-10-19-40  
In this community 30 years

**2. USUAL RESIDENCE OF DECEASED:**  
(a) State Mo. (b) County Jackson  
(c) City or town Kansas City  
(d) Street No. 2017 Park Ave.  
(e) If foreign born, how long in U. S. A. ? \_\_\_\_\_ years.

**3. (a) PRINT FULL NAME** Ben Rhodes  
8. (b) If veteran, name war No 8. (c) Social Security No. No

4. Sex Male 5. Color or race Negro 6. (a) Single, widowed, married, divorced. Married  
6. (b) Name of husband or wife Mary Frances Rhodes 6. (c) Age of husband or wife if alive Unknown years  
7. Birth date of deceased 3 25 1872  
(Month) (Day) (Year)

**8. AGE:** Years 68 Months 6 Days 24 If less than one day  
hr. \_\_\_\_\_ min. \_\_\_\_\_

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

10. Usual occupation none

11. Industry or business \_\_\_\_\_

**MOTHER FATHER**  
12. Name Unknown  
13. Birthplace Unknown  
14. Maiden name Unknown  
15. Birthplace Unknown

16. (a) Informant's own signature Record Clerk  
(b) Address Gen. Hosp. #2

17. (a) Burial (b) Date thereof 10-22-40  
(c) Place: burial or cremation Blue Ridge Lawn

18. (a) Signature of funeral director Henry Lawrence  
(b) Address 1905 E. 14th

19. (a) 10-22-40 (b) M. M. Cron  
(Date received local registrar) (Registrar's signature)

**MEDICAL CERTIFICATION**  
20. DATE OF DEATH: Month 10 day 19  
year 40 hour 9 minute 20 A. M.

21. I hereby certify that I attended the deceased from 9-22- 19 40 to 10-19- 19 40  
that I last saw him alive on 10-19- 19 40  
and that death occurred on the date and hour stated above.

Immediate cause of death Terminal Pneumonia Hypostatic  
Duration \_\_\_\_\_

Due to Neoplasm of Bladder  
Due to (Malignant)

Other conditions (include pregnancy within 3 months of death) 51

**PHYSICIAN**  
Major findings: \_\_\_\_\_  
Of operations \_\_\_\_\_  
Of autopsy \_\_\_\_\_  
Underline the cause to which death should be charged statistically

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? \_\_\_\_\_  
(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 Gen. Hosp. #2 Date signed 10-22-40

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.

100-671-30  
1-11-40

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**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.....

*E. Sterling Bells*

Licensed Embalmer No. *3178*

P. O. Address *1811 E. 12th St. K.C.*

**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.**