

S. No. 2  
-11-10-39  
-5-17-39  
-I X21492

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. 2790

Registration District No. 584

Primary Registration District No. 7227-5535 Registrar's No. \_\_\_\_\_

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

46  
0  
0

1. PLACE OF DEATH:  
(a) County Newell  
(b) City or town West Plains, Mo  
(c) Name of hospital or institution: \_\_\_\_\_  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether years, months or days)

In this community 30 yrs  
years, months or days)  
8. (a) PRINT FULL NAME Gas. Walter Rhodes  
3. (b) If veteran, name war ✓ 3. (c) Social Security No. \_\_\_\_\_

4. Sex m 5. Color or race w 6. (a) Single, widowed, married, divorced m  
6. (b) Name of husband or wife Maudie Rhodes 6. (c) Age of husband or wife if alive 50 years  
7. Birth date of deceased 3-24-1888  
(Month) (Day) (Year)

8. AGE: Years 52 Months 9 Days 7 If less than one day hr. \_\_\_\_\_ min. \_\_\_\_\_

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

10. Usual occupation Laborer Re-ty Dept

11. Industry or business \_\_\_\_\_  
12. Name John Rhodes  
13. Birthplace unk (City, town, or county) (State or foreign country)  
14. Maiden name Sarah Boone  
15. Birthplace ennessee (City, town, or county) (State or foreign country)

16. (a) Informant Mrs. J. W. Rhodes  
(b) Address West Plains, Mo

17. (a) Burial (b) Date thereof 1-3-41  
(Burial, cremation, or removal) (Month) (Day) (Year)  
(c) Place: burial or cremation Chapin Cemetery

18. (a) Signature of funeral director Kabuhn Mortuary  
(b) Address West Plains, Mo

19. (a) 1-20-41 (b) Vida W. SIMONS  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:  
(a) State Missouri County Newell  
(c) City or town West Plains, Mo  
(If outside city or town limit, write "RURAL")  
(d) Street No. R. F. 2  
(If rural, give location)  
(e) If foreign born, how long in U. S. A. ? 0 years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 1 day 1  
year 1941 hour 3 minute 50 P. M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_, 19\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_;  
that I last saw h\_\_\_\_\_ alive on \_\_\_\_\_, 19\_\_\_\_;  
and that death occurred on the date and hour stated above.

Immediate cause of death Acute Intoxication  
Chronic Gastritis

Due to \_\_\_\_\_  
Other conditions \_\_\_\_\_  
(Include pregnancy within 3 months of death)

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? \_\_\_\_\_ (City or town) (County) (State)  
(d) Did injury occur in or about home, on farm, in industrial place, in public place? \_\_\_\_\_

(e) While at work? \_\_\_\_\_ (Specify type of place)  
(f) Means of injury \_\_\_\_\_  
23. Signed W. J. Rhodes (M. D. or D.O.)  
W. J. Rhodes Date signed 3-41

RECEIVED

District Health Officer No. 5,

District File Number 241134

Date Filed \_\_\_\_\_

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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 Apprentices No. \_\_\_\_\_  
working under my personal supervision.

Signed

*L. A. Roberts*

Licensed Embalmer No. 3435

P. O. Address West Haven, N.

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.