

No. 2
-1-4-41
5-17-39
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 24170

FILED AUG 16 1941
Registration District No. 2

Primary Registration District No. 1002

Registrar's No. 2709

48
3
8

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

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: Home
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether)
In this community 25 yr 1 years, months or days (Specify whether)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson 048
(c) City or town Kansas City 3
(If outside city or town limits, write "RURAL") 2
(d) Street No. 2212 Brighton St
(If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____ 0

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 18
year 1941 hour 8:00 minute _____ A. M.
21. I hereby certify that I attended the deceased from August 1939
_____ 19 _____ to July 18 19 41
that I last saw him alive on July 17 _____ 19 41
and that death occurred on the date and hour stated above.
Immediate cause of death Coronary Occlusion Duration _____

3. (a) PRINT FULL NAME Josephine C. Rhodes

3. (b) If veteran, name war _____ 3. (c) Social Security No. None

4. Sex Female 5. Color or race White
6. (a) Single, widowed, married, divorced Widowed
6. (b) Name of husband or wife Jacob E. Rhodes 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased January 9 1864
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>76</u>	<u>6</u>	<u>9</u>	_____ hr. _____ min.

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

10. Usual occupation Housewife
11. Industry or business Same

MOTHER FATHER { 12. Name Unknown
13. Birthplace Unknown 9
(City, town, or county) (State or foreign country)
14. Maiden name Unknown
15. Birthplace Unknown 9
(City, town, or county) (State or foreign country)

16. (a) Informant A. B. Rhodes
(b) Address 2620 Quincy St.

17. (a) Burial (b) Date thereof 7/21/41
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Mt. Washington

18. (a) Signature of funeral director Rose & Henderson
(b) Address 4139 E. 15th St. K.C. Mo

19. (a) 7-19-41 (b) M. M. Crowe
(Date received local registrar) (Registrar's signature)

Due to 94W
Due to 94W
Other conditions (Include pregnancy within 3 months of death)
Major findings:
Of operations _____
Of autopsy _____
PHYSICIAN _____
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?

While at work? _____ (Specify type of place)
(a) Means of injury _____
23. Signature Ralph Perry M.D. (M. D. or other) 0
Address 4800 E. 24th St. K.C. Mo Date signed 8-14-41

361 (Licensed Embalmer's Statement on Reverse Side)

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

G. E. Henderson

Licensed Embalmer No. *3657*

P. O. Address *196, Me*

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, fact should be so stated above.