

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

1. PLACE OF DEATH:
(a) County Mississippi
(b) City or town Charleston Rural
(If outside city or town limits, write "RURAL" and name of township)
(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)
In this community 6 wks years, months or days

3. (a) PRINT FULL NAME CHARLES ROBERT RHODES
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 Married
6. (b) Name of husband or wife Mrs Chas R Rhoads 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased Sept 6 1918
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>24</u>	<u>0</u>	<u>12</u>	_____ hr. _____ min.

9. Birthplace Alexander West Virginia
(City, town, or county) (State or foreign country)

10. Usual occupation Cadet - Flying School

11. Industry or business _____

MOTHER FATHER { 12. Name Samuel F. Rhoads

13. Birthplace OK
(City, town, or county) (State or foreign country)

14. Maiden name OK

15. Birthplace _____
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Just of Aeronautics

(b) Address Sikeston Mo.

17. (a) Removal (b) Date thereof 9-18-42
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Canton Ohio

18. (a) Signature of funeral director Welsh Funeral Home
(b) Address Sikeston Mo.

19. (a) 11-16-48 (b) Mrs. J. B. Bordurant
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State Ohio (b) County _____
(c) City or town Canton
(If outside city or town limits, write "RURAL")
(d) Street No. 1412 17th St N West
(If rural, give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country no

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month Sept day 18th
year 1942 hour 9 minute 15 A. M.
21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____;
that I last saw him alive on Aug 7, 1942
and that death occurred on the date and hour stated above.

Immediate cause of death Aircraft accident resulting in complete mutilation.
Due to _____
Due to _____
Other conditions (Include pregnancy within 3 months of death) _____

Major findings: Of operations 13 14
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) Accident
(b) Date of occurrence Sept 18, 1942
(c) Where did injury occur? 2 1/2 mi. SW of Charleston Mo
(City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place?
Farmers field
While at work? yes (Specify type of place) (e) Means of injury _____
23. Signature Robert J. Stephens M. D. or other _____
Address 3072 AAF FAD Sikeston Mo Date signed 9-18-42

RECEIVED

District Health Office No. 2

District File Number 1148-1562

Date Filed 11-22-48

DEC 17 1948

FEB 1 1949

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 *Raymond Crews*

Licensed Embalmer No. 3467

P. O. Address *Sikeston 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, fact should be so stated above.