

Registration District No. 149

Primary Registration District No. 1002

Registrar's No. 455

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: General Hospital No. 2  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 1-16-43-1-25-43  
(Specify whether years, months or days) 49 years  
In this community \_\_\_\_\_

3. (a) PRINT FULL NAME JULIA RHODES  
(b) If veteran, name war no  
(c) Social Security No. none

4. Sex Female  
5. Color or race Negro  
6. (a) Single, widowed, married, divorced Widow  
(b) Name of husband or wife Joseph Rhodes  
(c) Age of husband or wife alive Deceased years  
7. Birth date of deceased July 1 1877  
(Month) (Day) (Year)

8. AGE: Years 65 Months 6 Days 24  
If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

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

10. Usual occupation unemployed

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

MOTHER FATHER  
12. Name Andrew Jackson  
13. Birthplace Lafayette County Missouri  
(City, town, or county) (State or foreign country)  
14. Maiden name Harriett Perkins  
15. Birthplace Lafayette County Missouri  
(City, town, or county) (State or foreign country)

16. (a) Informant record clerk  
(b) Address General Hospital No. 2

17. (a) Burial (b) Date thereof Jan 19 1943  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Missouri

18. (a) Signature of funeral director West Appleton Jones  
(b) Address 1901 Vine St.

19. (a) 1-28-43 (b) M. M. Crow  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:  
(a) State Missouri (b) County Jackson  
(c) City or town Kansas City  
(If outside city or town limits, write "RURAL")  
(d) Street No. 2012 E. 12  
(If rural, give location) no  
(e) Citizen of foreign country? no (Yes or No)  
If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month January day 25  
year 1943 hour 9:40 minute P. M.

21. I hereby certify that I attended the deceased from January 16 1943 to January 25 1943  
that I last saw her alive on January 25 1943  
and that death occurred on the date and hour stated above.

Immediate cause of death Acidosis Duration \_\_\_\_\_

Due to Cholangitis & Diabetes Mellitis

Due to U

Other conditions Arteriosclerotic changes of lower leg  
(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? \_\_\_\_\_

While at work? \_\_\_\_\_ (Specify type of place)  
Means of injury \_\_\_\_\_  
23. Signature G. D. Turner (M. D. doctor)  
Address Gen. Hosp. 42401 E. 28 Date signed 1-27-43

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

*C. J. West*

Licensed Embalmer No. *2710*

P. O. Address: *K.C. 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.**