

FILED MAR 6 1944

Registration District No. *749*

Primary Registration District No. *1002*

Registrar's No. *898*

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: *K. U. General Hospital No. 10*
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution *2 days* (Specify whether)

In this community
years, months or days

3. (a) PRINT FULL NAME *Margaretta Rhoda*

3. (b) If veteran, name war *✓* 3. (c) Social Security No. _____

4. Sex *female* / race *w* 5. Color or race *w*
6. (a) Single, widowed, married *divorced*
6. (b) Name of husband or wife *Henry Rhoda* 6. (c) Age of husband or wife if alive *26* years
7. Birth date of deceased *11-1922*
(Month) (Day) (Year)

8. AGE: Years *21* Months *8* Days *12* If less than one day _____ hr. _____ min.

9. Birthplace *Rose Hill Iowa*
(City, town, or county) (State or foreign country)

10. Usual occupation *waitress*

11. Industry or business _____

MOTHER FATHER

12. Name *Rex Marion Rhoda*

13. Birthplace *Lowe Iowa*
(City, town, or county) (State or foreign country)

14. Maiden name *Beulah T. Lewis*

15. Birthplace *Kansas City Mo*
(City, town, or county) (State or foreign country)

16. (a) Informant *Henry Rhoda*

(b) Address *510 W 9 Kansas City Mo*

17. (a) *Burial* (b) Date thereof *2-23-44*
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation *Single Cemetery, Ray Co.*

18. (a) Signature of funeral director *Charles [unclear]*
(b) Address *Excelsior Springs Mo*

19. (a) *2-24-44* (b) *N. E. Brown*
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State *Mo* (b) County *Jackson*
(c) City or town *Kansas City*
(If outside city or town limits, write "RURAL")
(d) Street No. *570 W. 9th*
(If rural, give location)
(e) Citizen of foreign country? *no* (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month *February* day *23*
year *1944* hour *12* minute *10* A. M.

21. I hereby certify that I attended the deceased from *February 21*, 19*44*, to *February 23*, 19*44*, that I last saw her alive on *February 23*, 19*44*, and that death occurred on the date and hour stated above.

Immediate cause of death *Encephalitis (Infectious)*

Due to _____

Due to _____

Other conditions (Include pregnancy within 3 months of death) _____

Major findings: Of operations *37C*

Of autopsy *See above*

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 *A. E. Upsher* (M. D. or other) *M.D.*
Address *Med. Dir. Gen'l. Hosp* Date signed *2-23-44*

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

NOV 1 1944

MAR 2 2 1944

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 will be

....., Registered Apprentice No.
working under my personal supervision.

Signed

Claude Richard

Licensed Embalmer No. 2751

P. O. Address

Excelsior Springs, 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.