

FILED SEP 7 1944
Registration District No. **42**

Primary Registration District No. **1020**

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

1. PLACE OF DEATH:
 (a) County **Buchanan**
 (b) City or town **St. Joseph**
(If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution:
Missouri Methodist Hospital
(If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution **2 Days (Hospital)**
(Specify whether
 In this community **50 Years**
years, months or days)

2. USUAL RESIDENCE OF DECEASED:
 (a) State **Missouri** (b) County **Buchanan**
 (c) City or town **St. Joseph**
(If outside city or town limits, write "RURAL")
 (d) Street No. **1924 So. 11th. St.**
(If rural, give location)
 (e) Citizen of foreign country? **No.** (Yes or No)
 If yes, name country **0**

3. (a) PRINT FULL NAME Sarah B. Rody
 3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month September Day 1
 year **1944** hour **11** minute **30 A.M.**

4. Sex **Female** 5. Color or race **White**
 6. (a) Single, widowed, married, divorced **Married**
 6. (b) Name of husband or wife **John Rody** 6. (c) Age of husband or wife if alive **83** years
 7. Birth date of deceased **September 22, 1867**
(Month) (Day) (Year)

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

8. AGE:	Years	Months	Days	If less than one day
	76	11	9	hr. _____ min. _____

Immediate cause of death:
Chronic Myocarditis & Arteriosclerosis
 Due to **Empyema of the Lungs**
 Due to **Cholecystitis & Cholelithiasis**
 Other conditions: _____
(Include pregnancy within 3 months of death)

9. Birthplace **Unknown Penn.**
(City, town, or county) (State or foreign country)

10. Usual occupation **Housewife**

11. Industry or business _____

MOTHER FATHER
 12. Name **Pete Mertz**
 13. Birthplace **Unknown Penn.**
(City, town, or county) (State or foreign country)
 14. Maiden name **Unknown**
 15. Birthplace **Unknown Unknown**
(City, town, or county) (State or foreign country)

Major findings:
 Of operations _____
 Of autopsy **Above 126**
PHYSICIAN
 Underline the cause to which death should be charged statistically.

16. (a) Informant **Mr. John Rody**
 (b) Address **1924 So. 11th. St.**

17. (a) **Burial** (b) Date thereof **Sept. 4, 1944**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Ashland Cemetery**

18. (c) Signature of funeral director **Norman W. Sidenfaden**
 (b) Address **1802 Union St. St. Joseph, Mo.**

19. (a) **9/2/44** (b) **Nelson J. Goble**
(Date received local registrar) (Registrar's signature)

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?

(Specify type of place)
 While at work? _____ (a) Means of injury _____
23. Signature: Alexton Street (M. D. or other) M.D.
 Address **218 7th St. St. Joseph** Date signed **9/2/44**

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.....

Robert H Reed

Licensed Embalmer No.

3745

P. O. Address.....

St Joseph 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.