

114 0000
WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH:
 (a) County Wright
 (b) City or town Wright "RURAL"
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution: Missouri State Hosp
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution: 1 (Specify whether
 years, months or days) Lifetime

2. USUAL RESIDENCE OF DECEASED:
 (a) State Missouri (b) County Wright 114
 (c) City or town Wright
 (If outside city or town limits, write "RURAL")
 (d) Street No. 770 - Rural
 (If rural, give location)
 (e) Citizen of foreign country? No (Yes or No)
 -If yes, name country: No

3. (a) PRINT FULL NAMES SUSIE Catherine Rhodes
 3. (b) If veteran, name war No
 3. (c) Social Security No. No.

MEDICAL CERTIFICATION
 20. DATE OF DEATH: Month Sept. day 27
 year 1944 hour 3:00 minute P. M.

4. Sex Female 5. Color or race white
 6. (a) Single, widowed, married, divorced MARRIED
 6. (b) Name of husband or wife George W Rhodes
 6. (c) Age of husband or wife if alive 61 years
 7. Birth date of deceased: (Month) (Day) (Year)

21. I hereby certify that I attended the deceased from Sept. 2 - 1944 to Sept. 27 - 1944;
 that I last saw her alive on Sept. 27 - 1944;
 and that death occurred on the date and hour stated above.
 Immediate cause of death: Dysphoid fever

8. AGE: Years 49 Months 11 Days 14 If less than one day
 hr. min.

Due to: Dysphoid fever

9. Birthplace Chariton County, Mo.
 (City, town, or county) (State or foreign country)

Due to: /

10. Usual occupation Housewife

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

11. Industry or business No

Major findings: Of operations

12. Name John W Owens

Of autopsy

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

14. Maiden name PERTRUDE Owens

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

16. (a) Informant George W. Rhodes

(b) Address MTN. GROVE, Mo.

17. (a) Burial (b) Date thereof: (Month) (Day) (Year)

(c) Place: burial or cremation Long St

18. (a) Signature of funeral director E. J. Barber

(b) Address MTN. GROVE, Mo.

19. (a) 10/2/44 (b) H. J. Owen
 (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?

While at work? (Specify type of place) (e) Means of injury

23. Signature W. J. Owen M.D. (M. D. or other)
 Address Wright, Mo. Date signed 9-28-44

Duration
 Underline the cause to which death should be charged statistically.

141
0/5/44

OCT 9 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 _____, Registered Apprentice No. _____, working under my personal supervision.

Signed Larvin P. Hall
Licensed Embalmer No. 2784
P. O. Address Wainwright, Pa.

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.