

FILED NOV 28 1945

Registration District No. \_\_\_\_\_

Primary Registration District No. 4479

Registrar's No. 51

1. PLACE OF DEATH:

(a) County Schuyler

(b) City or town Queen City  
(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) 1

(d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether \_\_\_\_\_)

In this community \_\_\_\_\_ years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Schuyler 98

(c) City or town Queen City 0  
(If outside city or town limits, write "RURAL") 0

(d) Street No. \_\_\_\_\_ (If rural, give location)

(e) Citizen of foreign country? no (Yes or No) no  
If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION

3. (a) PRINT FULL NAME Minnie M. Rhodes

3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

20. DATE OF DEATH: Month Nov day 20  
year 44 hour 6 minute 30 P.M.

4. Sex Female 5. Color or race white 6. (a) Single, widowed, married, divorced widowed

6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased: May 3 1869  
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from May 21, 1944 to Nov 20, 1944  
that I last saw her alive on Nov 15, 1944  
and that death occurred on the date and hour stated above.

Immediate cause of death: Cancer of the Esoph 8 months

8. AGE: Years 75 Months 6 Days 18  
If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions (Include pregnancy within 3 months of death) 46

9. Birthplace Lake Horn Miss.  
(City, town, or county) (State or foreign country)

10. Usual occupation Housewife

Major findings: Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

PHYSICIAN \_\_\_\_\_

Underline the cause to which death should be charged statistically.

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

MOTHER FATHER { 12. Name J. A. Stevenson

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

14. Maiden name Clemmie Eldridge

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

16. (a) Informant Mrs. Clair Edrus

(b) Address Kirksville Mo.

17. (a) burial (b) Date thereof Nov. 23, '44  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Myers Cemetery

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? \_\_\_\_\_

18. (a) Signature of funeral director Wm O Webb

(b) Address Queen City Mo

19. (a) Nov. 22, 1944 (b) A. A. Justice  
(Date received local registrar) (Registrar's signature)

(Specify type of place) \_\_\_\_\_

While at work? \_\_\_\_\_ (e) Means of injury 2

23. Signature D. P. Snow (M. D. or other) D.D.  
Address Queen City Date signed Nov 21

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

200

DEC 4 1944

RECEIVED

District Health Officer No. 10

District File Number 11-44-1925

Date Filed NOV 25 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 Self

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

Signed Wm R West

Licensed Embalmer No. 2882

P. O. Address Dulles City 910

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.