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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED FEB 24 1945

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 7192

Registration District No. 317 Primary Registration District No. 3067 Registrar's No. 462

1. PLACE OF DEATH:

(a) County St. Louis
(b) City or town Ladue (If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: 8 Upper Ladue Road (If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution (Specify whether In this community 50 years years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County St. Louis
(c) City or town Ladue (If outside city or town limits, write "RURAL")
(d) Street No. 8 Upper Ladue Road (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME Boyle O. Rodes
3. (b) If veteran, name war World War 1
3. (c) Social Security No. 492-01-5504
4. Sex Male
5. Color or race White
6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife Harriet M. Rodes
6. (c) Age of husband or wife if alive 50 years
7. Birth date of deceased March (Month) 25 (Day) 1882 (Year)

8. AGE:	Years	Months	Days	If less than one day
	62	10	21	hr. min.

9. Birthplace Danville, (City, town, or county) Kentucky (State or foreign country)
10. Usual occupation Insurance Broker
11. Industry or business Self
FATHER
12. Name Charles H. Rodes
13. Birthplace Danville, (City, town, or county) Kentucky (State or foreign country)
MOTHER
14. Maiden name Mary Davis
15. Birthplace St. Louis, (City, town, or county) Missouri (State or foreign country)
16. (a) Informant Mrs. Boyle O. Rodes
(b) Address 8 Upper Ladue Road
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-19-45 (Month) (Day) (Year)
(c) Place: burial or cremation Bellefontaine Cemetery
18. (a) Signature of funeral director Wagoner Mortuary
(b) Address 4161 Lindell Blvd.
19. (a) FEB 17 1945 (Date received local registrar) (b) E. G. Y. Gavron (Registrar's signature) 40 Bud

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month February day 16 year 1945 hour 9 minute 15 A. M.
21. I hereby certify that I attended the deceased from Death without medical attendance, to , 19 ; that I last saw h alive on , 19 ; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Coronary thrombosis	
Due to	
Due to	
Other conditions (Include pregnancy within 3 months of death)	
Major findings: Of operations	
Of autopsy As above	

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

23. Signature E. G. M. Gavron M.D. (M. D. or other)
Address 601 Brentwood Blvd. Date signed 2/17/45

701 (Licensed Embalmer's Statement on Reverse Side)

AUG 20 1946

MAR 29 1945

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 Neville B. Holewitter

Licensed Embalmer No. 3686

P. O. Address 4161 Lindell

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.