

S. No. 2
M-8-43
v. 5-17-39
X37823

15722

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No.

FILED MAY 18 1945

Registration District No. 17

Primary Registration District No. 5303

Registrar's No. 72

1. PLACE OF DEATH:

(a) County Dallas

(b) City or town Elkland Rural
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution Jackson typ
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution.....
(Specify whether
In this community 11 yrs
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Dallas

(c) City or town Elkland Rural
(If outside city or town limits, write "RURAL")

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

(e) Citizen of foreign country? (Yes or No)
If yes, name country.....

3. (a) PRINT FULL NAME ARTHUR F. RHODES

3. (b) If veteran, name war.....

3. (c) Social Security No.

4. Sex Male 5. Color or race White

6. (a) Single, widowed, married, divorced, married

6. (b) Name of husband or wife Nellie

6. (c) Age of husband or wife if alive 68 years

7. Birth date of deceased July 28 1878
(Month) (Day) (Year)

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

9. Birthplace accova Ind
(City, town, or county) (State or foreign country)

10. Usual occupation paring contractor

11. Industry or business.....

12. Name unknown

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

14. Maiden name.....

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

16. (a) Informant Nellie Rhodes

(b) Address Elkland Mo

17. (a) Burial (b) Date thereof 4-15-45
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Nacodouga

18. (a) Signature of funeral director L. B. Jones

(b) Address Buffalo Mo

19. (a) April 28 1945 (b) me a D. Howe
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 19
year 1945 hour 8 minute..... M.

21. I hereby certify that I attended the deceased from Jan 1, 1945 to April 13, 1945
that I last saw him alive on April 7, 1945
and that death occurred on the date and hour stated above.

Immediate cause of death Organic heart disease Duration 10 years

Due to Agaric C

Due to arterio sclerosis 20 yrs
(Injury)

Other conditions (include pregnancy within 3 months of death) none

Major findings: Of operations none

Of autopsy none

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 L. B. Jones (M. D. or other) MD

Address Buffalo Mo Date signed 4-17-45

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

1371

RECEIVED

District Health Officer No. 7,

District File Number 4-75-462

Date Filed 5-19-45

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 Wm. B. Jones

Licensed Embalmer No. 4222

P. O. Address Buffalo, 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.