

Registration District No. 27

Primary Registration District No. 3005

1. PLACE OF DEATH:

(a) County Bates
(b) City or town Butler
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
Butler Memorial
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 12 days
(Specify whether
In this community
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State mo (b) County Bates
(c) City or town Rural
(If outside city or town limit, write "RURAL")
(d) Street No. Mings Top
(If rural, give location)
(e) If foreign born, how long in U. S. A. _____ years.

3. (a) PRINT FULL NAME Lenora Edith Rhoades

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

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

6. (b) Name of husband or wife Ira M Rhoades 6. (c) Age of husband or wife if alive 61 years

7. Birth date of deceased Sept 8 1893
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
51 11 20 hr. _____ min.

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

10. Usual occupation Housewife

11. Industry or business _____

MOTHER FATHER { 12. Name W. J. Halcomb

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

14. Maiden name Maggie Plane

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

16. (a) Informant Ira M Rhoades
(b) Address Adrain Mo

17. (a) Burial (b) Date thereof Sept 2 1945
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Crescent Hill
(a) Signature of funeral director Herbert Arnold
(b) Address Creston Mo

19. (a) Sept 1, 1945 (b) Bessie Compton
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug day 30
year 1945 hour 4 minute 55 a. M.

21. I hereby certify that I attended the deceased from Aug 15, 1945, to Aug 30, 1945, that I last saw her alive on Aug 29, 1945, and that death occurred on the date and hour stated above.

Immediate cause of death: Generalized Carcinomatous Lesions, Colon & mesenteric Glands. Primary in Right Ovary
Due to _____
Other conditions (Include pregnancy within 3 months of death) _____

Duration

PHYSICIAN

Major findings: Of operations _____
Of autopsy 190

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 Carter W. Sutton (M. D. or other) MD
Address Butler Mo Date signed 8/31/45

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

1300

SEP 18 1945

RECEIVED

District Health Officer No. 7,

District File Number 8-45-9-18

Date Filed 9-8-45

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.....

Robert Arnold

Licensed Embalmer No. 3671

P. O. Address Craghton, 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, above space should be left blank.