

8-43  
5-17-39  
X37823

FILED APR 9 1946 STANDARD CERTIFICATE OF DEATH

State File No. 8483

Registration District No. 32

Primary Registration District No. 11044

Registrar's No. 14

1. PLACE OF DEATH:

(a) County Bollinger  
(b) City or town Zalma  
(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)  
(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 Bollinger  
(c) City or town Zalma  
(If outside city or town limits, write "RURAL")  
(d) Street No. Wynnes Top  
(If rural, give location)  
(e) Citizen of foreign country? no (Yes or No)  
If yes, name country.....

3. (a) PRINT FULL NAME Martha Jane Rhodes,

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

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

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

7. Birth date of deceased May 17 1870  
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day  
76 8 13 ..hr. ..min.

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

10. Usual occupation House Work

11. Industry or business.....

MOTHER { 12. Name James Anthony  
13. Birthplace Un Known  
(City, town, or county) (State or foreign country)

FATHER { 14. Maiden name Addie Clark,  
15. Birthplace Un Known  
(City, town, or county) (State or foreign country)

16. (a) Informant William M Rhodes  
(b) Address Zalma Missouri,

17. (a) Burial (b) Date thereof 2 1 1946  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Plesant Hill

18. (a) Signature of funeral director Wattens Service

(b) Address Puxico Mo

19. (a) Mar. 13 1946 (b) Willie N. Caudenburgh  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan day 30  
year 1946 hour 2 minute A M.

21. I hereby certify that I attended the deceased from Jan 15 1946 to Jan 30 1946  
that I last saw him alive on Jan 28 1946  
and that death occurred on the date and hour stated above.

Immediate cause of death Chronic myocarditis  
Due to Toxic Eitire, Smilitz  
and  
Due to Weakness from a Case of Pneumonia

Other conditions (Include pregnancy within 3 months of death)

Major findings:  
Of operations **ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED**  
Of autopsy.....  
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?

While at work? (Specify type of place) (c) Means of injury 2  
23. Signature E.C. Masters (M. D. or other) Dr.  
Address Advance, Mo. Date signed 9.2.46

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

Public Health Certificate No. 4  
Subject File Number 446-1906  
Date Filed 4-8-46

**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 Lynnan Steele  
Licensed Embalmer No. 2476  
P. O. Address Wexter 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.**

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUSTHE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATHState File No. AprilRegistration District No. 32Primary Registration District No. 40X4Registrar's No. 14

## 1. PLACE OF DEATH:

(a) County Bollinger  
(b) City or town Zalma  
(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)

(d) Length of stay: In hospital or institution \_\_\_\_\_  
(Specify whether \_\_\_\_\_)  
In this community \_\_\_\_\_  
years, months or days

## 3. (a) PRINT FULL NAME

Martha J. Rhodes

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

3. (c) Social Security No. \_\_\_\_\_

4. Sex F 5. Color or race W 6. (a) Single, widowed, married, divorced \_\_\_\_\_

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

7. Birth date of deceased May 11 1926  
(Month) (Day) (Year)8. AGE: Years 76 Months \_\_\_\_\_ Days \_\_\_\_\_ (If less than one day) \_\_\_\_\_ min.9. Birthplace \_\_\_\_\_ (City, town, or county) (State or foreign country) Mo

10. Usual occupation \_\_\_\_\_

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

12. Name \_\_\_\_\_

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 \_\_\_\_\_

(b) Address \_\_\_\_\_

17. (a) \_\_\_\_\_ (b) Date thereof \_\_\_\_\_  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation \_\_\_\_\_

18. (a) Signature of funeral director \_\_\_\_\_

(b) Address \_\_\_\_\_

19. (a) \_\_\_\_\_ (b) \_\_\_\_\_  
(Date received local registrar) (Registrar's signature)

## 2. USUAL RESIDENCE OF DECEASED:

(a) State \_\_\_\_\_ (b) County \_\_\_\_\_

(c) City or town \_\_\_\_\_  
(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 \_\_\_\_\_

## MEDICAL CERTIFICATION

20. DATE OF DEATH: Month \_\_\_\_\_  
year \_\_\_\_\_ hour \_\_\_\_\_ minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_ to \_\_\_\_\_, 19\_\_\_\_;

that I last saw him \_\_\_\_\_ alive on \_\_\_\_\_, 19\_\_\_\_;  
and that death occurred on the date and hour stated above.

Immediate cause of death \_\_\_\_\_

Due to bronchial pneumonia \_\_\_\_\_

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

Other conditions \_\_\_\_\_  
(Include pregnancy within 3 months of death)Major findings: \_\_\_\_\_  
Of operations \_\_\_\_\_

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

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 E. C. Weathers (M. D. or other) MDAddress Adrian, Mo Date signed \_\_\_\_\_

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

7415

SUPPLEMENTARY

ADDITIONAL  
SUPPLEMENTARY  
INFORMATION  
REQUESTED

Duration

PHYSICIAN

Underline  
the cause to  
which death  
should be  
charged sta-  
tistically.

8483