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Rev. 5-17-39  
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DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

FILED OCT 16 1946 STANDARD CERTIFICATE OF DEATH

State File No. ....

Registration District No. 42

Primary Registration District No. 1000

Registrar's No. 1146

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

1. PLACE OF DEATH:

(a) County Buchanan  
(b) City or town St. Joseph  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: State Hospital #2  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 1 year, 6 months  
(Specify whether years, months or days) 9 days

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Ray  
(c) City or town Richmond  
(If outside city or town limits, write "RURAL")  
(d) Street No. \_\_\_\_\_ (If rural, give location)  
(e) Citizen of foreign country? No (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME

Laura Rhodes

3. (b) If veteran, name war NO

3. (c) Social Security No. NONE

4. Sex Female race White  
5. Color or race White  
6. (a) Single, widowed, married, divorced Widowed  
6. (b) Name of husband or wife Rhodes  
6. (c) Age of husband or wife if alive Deceased years  
7. Birth date of deceased July 21 1860  
(Month) (Day) (Year)

8. AGE: Years 86 Months 2 Days 14  
If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

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

10. Usual occupation House wife

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

MOTHER FATHER

12. Name D. B. Rhodes  
13. Birthplace Virginia  
(City, town, or county) (State or foreign country)  
14. Maiden name Sarah Ziegler  
15. Birthplace Virginia  
(City, town, or county) (State or foreign country)

16. (a) Informant Records State Hosp #2  
(b) Address St. Joseph, Mo.

17. (a) Date of burial, cremation, or removal 10-7-46  
(Month) (Day) (Year)  
(c) Place: burial or cremation Waverly Cem. - Hannibal, Mo.

18. (a) Signature of funeral director Harold W. Rumpfschler  
(b) Address Hannibal, Mo.

19. (a) Oct. 11, 1946 (Date received local registrar)  
H. J. Muller (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month October day 5  
year 1946 hour 4 minute 22 P. M.  
21. I hereby certify that I attended the deceased from March 26 1945 to October 5 1946  
that I last saw her alive on October 5 1946  
and that death occurred on the date and hour stated above.

Immediate cause of death Chronic Myocarditis  
Due to Myxoma Sclerosis

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

Other conditions (Include pregnancy within 3 months of death) \_\_\_\_\_

Major findings: Of operations 31A  
Of autopsy Completed Autopsy

Duration yr  
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? \_\_\_\_\_  
While at work? \_\_\_\_\_ (Specify type of place) \_\_\_\_\_  
Means of injury \_\_\_\_\_

23. Signature L. J. Thrust (M. D. or other)  
Address State Hosp #2 Date signed 10/6/46  
St. Joseph, Mo.

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

*John Roy Stamer*

Licensed Embalmer No.

*2435*

P. O. Address

*St Joseph*

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.