

FILED *SEP 1 1946*

State File No. _____

Registration District No. *286*

Primary Registration District No. *5974*

Registrar's No. _____

1. PLACE OF DEATH:

(a) County *Polk*
(b) City or town *RURAL - JOHNSON TWP.*
(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 *69 years*
years, months or days

3. (a) PRINT FULL NAME *Rhoda Belle Anderson*

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. *Single*

6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years (Month) (Day) (Year)

7. Birth date of deceased *Nov. 14 1894*
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
71 10 18 hr. min.

9. Birthplace *Louisville Ky. 1*
(City, town, or county) (State or foreign country)

10. Usual occupation *House work*

11. Industry or business *OWN HOME*

12. Name *DAVID C. ANDERSON*

13. Birthplace *Hart Co. Ky. 1*
(City, town, or county) (State or foreign country)

14. Maiden name *Febe White*

15. Birthplace *Sweet Springs Mo. 1*
(City, town, or county) (State or foreign country)

16. (a) Informant *Mathie Anderson*

(b) Address *Humansville mo*

17. (a) *BURIAL* (b) Date thereof *Oct. 15-1946*
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation *HUMANSVILLE CEM.*

18. (a) Signature of funeral director *E. H. Humm*

(b) Address *Humansville, mo*

19. (a) *Oct 17 1946* (b) *Paula Kirkpatrick*
(Date received local Registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State *MISSOURI* (b) County *Polk 84*
(c) City or town *RURAL*
(If outside city or town limits, write "RURAL")
(d) Street No. *JOHNSON TWP.*
(If rural, give location)
(e) Citizen of foreign country? *No* (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month *Oct.* day *12*
year *1946* hour *11* minute *30 A.M.*

21. I hereby certify that I attended the deceased from *September*
1946 to *October 11, 1946*
that I last saw her alive on *October 11, 1946*
and that death occurred on the date and hour stated above.

Immediate cause of death *Chronic nephritis* Duration _____

Due to _____

Due to _____

Other conditions (Include pregnancy within 3 months of death) *12/18*

Major findings: Of operations _____

Of autopsy _____

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 *G. H. Robinson* (M. D. or other) *M.D.*

Address *Humansville mo* Date signed *10/17/46*

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

MOTHER FATHER

33258

RECEIVED
District Health Officer No. 7
District No. 7-46573
Date filed 1/15/1960

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 me
....., Registered Apprentice No.
working under my personal supervision.

Signed E. H. Primm
Licensed Embalmer No. 4282
P. O. Address Humanville, Va.

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.