

7. S. No. 2
 OM-8-43
 ev. 5-17-39
 X37823

DEPARTMENT OF COMMERCE
 BUREAU OF THE CENSUS
FILED DEC 24 1946
 Registration District No. 205

THE STATE BOARD OF HEALTH OF MISSOURI
 STANDARD CERTIFICATE OF DEATH

41311

State File No. _____

Primary Registration District No. 5740

Registrar's No. 6

1. PLACE OF DEATH:
 (a) County Macon
 (b) City or town New Cambria (Rural)
 (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 2 yrs years, months or days

2. USUAL RESIDENCE OF DECEASED:
 (a) State Mo. (b) County Macon
 (c) City or town New Cambria (Rural)
 (If outside city or town limits, write "RURAL")
 (d) Street No. 1/2 mile west of town
 (If rural, give location)
 (e) Citizen of foreign country? no (Yes or No)
 If yes, name country _____

3. (a) PRINT FULL NAME MARION Rhodes
 3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

MEDICAL CERTIFICATION
 20. DATE OF DEATH: Month Dec day 3
 year 1946 hour 3 minute 9 M.

4. Sex Male 5. Color or race White
 6. (a) Single, widowed, married, divorced Married
 6. (b) Name of husband or wife Dora Rhodes 6. (c) Age of husband or wife if alive 65 years
 7. Birth date of deceased Jan 8, 1872
 (Month) (Day) (Year)

21. I hereby certify that I attended the deceased from Nov 24 1946 to Dec 3rd 1946
 that I last saw him alive on Dec 2nd 1946
 and that death occurred on the date and hour stated above.

8. AGE:	Years	Months	Days	If less than one day
	<u>74</u>	<u>10</u>	<u>25</u>	hr. _____ min. _____

Immediate cause of death Acute Myocarditis Duration 15.07
 Due to Congested Lung & Impaction of Bowels 102
 Due to _____

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

Other conditions _____
 (Include pregnancy within 3 months of death)

10. Usual occupation Farming

Major findings: _____
 Of operations 93A

11. Industry or business _____

Of autopsy no

12. Name Pete Rhodes
 13. Birthplace macon Co, Mo.
 (City, town, or county) (State or foreign country)

14. Maiden name Unknown
 15. Birthplace _____
 (City, town, or county) (State or foreign country)

16. (a) Informant Dora Rhodes
 (b) Address New Cambria, Mo.

17. (a) Burial (b) Date thereof Dec 5 1946
 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation East Cem. New Cambria, Mo.

18. (a) Signature of funeral director James Funeral Service
 (b) Address Ethel, Mo.

19. (a) Dec 4, 1946 (b) Alma M. Richland
 (Data received local registrar) (Registrar's signature)

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) _____ (e) Means of injury _____

23. Signature C. J. West (M. D. or other) _____
 Address New Cambria, MO Date signed Dec 3/46

PHYSICIAN

 Underline the cause to which death should be charged statistically.

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

40161

RECEIVED
District Health Officer No. 10
District File Number 12-46-234
Date Filed DEC 20 1946

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..... *E. A. Larson*

Licensed Embalmer No. *4027*

P. O. Address *Bucklin 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.