

**FILED APR 11 1947**  
**333**

Registration District No. **333**

Primary Registration District No. **6115**

Registrar's No. **29**

**1. PLACE OF DEATH:**

(a) County **Scott**

(b) City or town **Sikeston, Missouri, Richland**  
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: **Smith add**  
(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** **Cora E. Rhoden**

**3. (b) If veteran,** name war \_\_\_\_\_ **3. (c) Social Security No.** **None**

**4. Sex** **Female** **5. Color or race** **White**

**6. (a) Single, widowed, married,** **2 divorced Widowed**

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

**7. Birth date of deceased** **Aug. 8 1885**  
(Month) (Day) (Year)

<b>8. AGE:</b>	<b>Years</b>	<b>Months</b>	<b>Days</b>	<b>If less than one day</b>
	<b>61</b>	<b>6</b>	<b>20</b>	hr. _____ min.

**9. Birthplace** **Horhenwall Tennessee**  
(City, town, or county) (State or foreign country)

**10. Usual occupation** **Housewife**

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

**MOTHER FATHER** { **12. Name** **John Long**

{ **13. Birthplace** **Horhenwall Tennessee**  
(City, town, or county) (State or foreign country)

{ **14. Maiden name** **S. Stevens**

{ **15. Birthplace** **Horhenwall Tennessee**  
(City, town, or county) (State or foreign country)

**16. (a) Informant** **Mrs. Isom James**

**(b) Address** **746 Giboney St. Cape Girardeau**

**17. (a) Burial** **(b) Date thereof** **Mar 30 1947**  
(Burial, cremation, or removal) (Month) (Day) (Year)

**(c) Place: burial or cremation** **Fairmount Cemetery**

**18. (a) Signature of funeral director** **James R. Cady**

**(b) Address** **Cape Girardeau, Mo.**

**19. (a) 4-48-47 (b) Ma Henry**  
(Date received local registrar) (Registrar's signature)

**2. USUAL RESIDENCE OF DECEASED:**

(a) State **Missouri** (b) County **Cape Girardeau**

(c) City or town **Cape Girardeau, Mo.**  
(If outside city or town limits, write "RURAL")

(d) Street No. **746 Giboney St.**  
(If rural, give location)

(e) Citizen of foreign country? **NO** (Yes or No)

If yes, name country \_\_\_\_\_

**MEDICAL CERTIFICATION**

**20. DATE OF DEATH:** Month **Mar.** day **28**  
year **1947** hour **1** minute **40** A.M.

**21. I hereby certify that I attended the deceased from** **3-24-47**  
\_\_\_\_\_, 19\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_.

that I last saw her alive on **3-24** 19 **47**  
and that death occurred on the date and hour stated above.

Immediate cause of death **Pneumonia** **Duration 2 wks.**

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

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

Other conditions **Malignancy, Metast**  
(Include pregnancy within 3 months of death)

Major findings:  
Of operations \_\_\_\_\_

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

**ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED**

**PHYSICIAN** \_\_\_\_\_

**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 \_\_\_\_\_

**23. Signature** **H. B. Proggmorton** (M. D. or equivalent)

**Address** **Sikeston, Mo.** **Date signed** **1-Apr-47**

RECEIVED

District Health Office No.

District File Number 447-

Date Filed 4-9-47

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.....

*Ralph E. Beckman*

-, Registered Apprentice No. 493

working under my personal supervision.

Signed *James Richard Cady*

Licensed Embalmer No. 4309

P. O. Address *Cape Girardeau, 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.

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. April  
Registrar's No. 29

Registration District No. 003

Primary Registration District No. 6115

1. PLACE OF DEATH:

(a) County Scott  
(b) City or town 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 \_\_\_\_\_  
years, months or days)

3. (a) PRINT FULL NAME Core E. Rhoden

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

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

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

7. Birth date of deceased \_\_\_\_\_ (Month) \_\_\_\_\_ (Day) \_\_\_\_\_ (Year)

8. AGE: Years 61 Months 6 Days \_\_\_\_\_ (If less than one day, hr. \_\_\_\_\_ min. \_\_\_\_\_)

9. Birthplace \_\_\_\_\_ (City, town, or county) \_\_\_\_\_ (State or foreign country) Tenn

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

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

MOTHER FATHER

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

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

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

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

19. (a) \_\_\_\_\_ (Date received local registrar) (b) \_\_\_\_\_ (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 1941 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 \_\_\_\_\_

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

Other conditions Cancer of rectum  
(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 H. B. Dragnostewicz (M. D. or other) MD

Address \_\_\_\_\_ Date signed \_\_\_\_\_

SUPPLEMENTARY

Duration \_\_\_\_\_  
PHYSICIAN \_\_\_\_\_  
Underline the cause to which death should be charged statistically.

12098