No. 2
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X47070

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED SEP 15 1947

Registration District No. 128

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

Primary Registration District No. 2000

State File No. 27408

Registrar's No. 743

1. PLACE OF DEATH:
(a) County: Greene
(b) City or town: Springfield
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: 2301 N. National Ave /
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution ..... (Specify whether years, months or days)
In this community: 2Months

2. USUAL RESIDENCE OF DECEASED:
(a) State: Missouri (b) County: Greene 39
(c) City or town: Springfield 2
(If outside city or town limits, write "RURAL")
(d) Street No.: 2301 N National Ave. 6
(If rural, give location)
(e) Citizen of foreign country? ..... (Yes or No) 0
If yes, name country .....

3. (a) PRINT FULL NAME: Effie J. ERhoades
3. (b) If veteran, name war: No
3. (c) Social Security No.: No.
4. Sex: Female /
5. Color or race: White
6. (a) Single, widowed, married, divorced: Widow
6. (b) Name of husband or wife .....
6. (c) Age of husband or wife if alive ..... years
7. Birth date of deceased: Feb (Month) II (Day) 1871 (Year)

8. AGE: Years	Months	Days	If less than one day
76	6	12	hr. ..... min.

9. Birthplace: Missouri (City, town, or county) 0 (State or foreign country)
10. Usual occupation: Hose-ife
11. Industry or business .....
FATHER
12. Name: Charles Rice
13. Birthplace: Unknown (City, town, or county) 9 (State or foreign country)
MOTHER
14. Maiden name: Unknown.
15. Birthplace: 9 (City, town, or county) (State or foreign country)
16. (a) Informant: Ralph Rhoades
(b) Address: 2301 N. National
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof: 8-26-47 (Month) (Day) (Year)
(c) Place: burial or cremation: Foster Mo.
18. (a) Signature of funeral director: J.W.Klingner &Co.
(b) Address: 424E Commercial St.
19. (a) 8-25-47 (Date received local registrar) (b) W Handley MD (Registrar's signature) 111

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month: Aug. day: 23 year: 1947 hour: I 45 minute: P M.
21. I hereby certify that I attended the deceased from Aug 10 1947 to Aug 23 1947 that I last saw him alive on Aug. 22 1947 and that death occurred on the date and hour stated above.

Immediate cause of death: Cardiac failure (arteriosclerotic Heart disease).	Duration
Due to	
Due to	
Other conditions: Cerebral Hemorrhage (Include pregnancy within 3 months of death)	

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? —
While at work? ..... (Specify type of place) (e) Means of injury: 0 ✓
23. Signature: Geo Faulding (M. D. or other)
Address: Holland Bldg Springfield, Mo Date signed: Aug 25 '47

(Licensed Embalmer's Statement on Reverse Side)

NOV 15 1942

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 J B Klingner

Licensed Embalmer No. 3358

P. O. Address.....

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.