

No. 2
8-43
5-17-39
237823

FILED JUL 15 1948

Registration District No. **61**

Primary Registration District No. **4107**

Registrar's No. **30**

1. PLACE OF DEATH:

(a) County **Cedar**
(b) City or town **Eldorado Springs**
(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 **Rhoda Mae Hall**

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

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

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

7. Birth date of deceased **February 12 1897**
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
51 3 7 hr. min.

9. Birthplace **Jerico Springs Missouri**
(City, town, or county) (State or foreign country)

10. Usual occupation **Housekeeper**

11. Industry or business

MOTHER FATHER { 12. Name **Lorenza Dalpha Hall**

13. Birthplace **Hamball, Mo.**
(City, town, or county) (State or foreign country)

14. Maiden name **Estelle Owens**

15. Birthplace **Keyport, Ill.**
(City, town, or county) (State or foreign country)

16. (a) Informant **Alta Buck**

(b) Address **Jerico Springs, Mo**

17. (a) **Burial** (b) Date thereof **5 21 1948**
(Burial, cremation, or removal) (Month) (Day) (Year)

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

18. (a) Signature of funeral director **Chursh. Neale**
(b) Address **Stockton, Mo.**

19. (a) **5-27-48** (b) **J.C. Bronnon**
(Date received local registrar) (Registrar's Signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Mo.** (b) County **Cedar**
(c) City or town **Eldorado Springs**
(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.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **May** day **19**
year **1948** hour **5** minute **25P.** M.

21. I hereby certify that I attended the deceased from **25 April 1948** to **30 April 1948**
that I last saw her alive on **30 April 1948**
and that death occurred on the date and hour stated above.

Immediate cause of death **Carcinoma of uterine type undifferentiated, with metastases**
Due to

Due to
Other conditions (include pregnancy within 3 months of death)

Major findings: Of operations **290**
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) (c) Means of injury
23. Signature **Doc W. Gentry** (M. D. or other) **MD**
Address **Nevada, Mo.** Date signed **22 May 48**

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

RECEIVED
District Health Officer No. 7,
District File Number 798
Date Filed 7-14-48

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 Melvin Churchill

Licensed Embalmer No. 3272

P. O. Address Stockton, Ca

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.

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUSTHE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATHState File No. JulyRegistration District No. 61Primary Registration District No. 4107Registrar's No. 30

1. PLACE OF DEATH:

- (a) County Cedar
 (b) City or town Osage Springs
 (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 Rhoda M. Hall

3. (b) If veteran, name war _____

3. (c) Social Security No. _____

4. Sex
- F
5. Color or race
- W
6. (a) Single, widowed, married, divorced
- S

6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____

7. Birth date of deceased
- Jul 12 1915
-
- (Month) (Day) (Year)

8. AGE: Years
- 51
- Months _____ Days _____ If less than one day _____ hr. _____ min.

9. Birthplace _____ (City, town, or county) _____ (State or foreign country)
- Mo

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 _____

18. (a) Signature of funeral director _____

- (b) Address _____

19. (a)
- 5-27-48
- (b)
- J. B. Brown
-
- (Date received local registrar) (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
- 1948
- 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 _____

Duration _____

Due to _____

Due to _____

Other conditions _____
(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 _____

Signature _____ (M. D. or other) _____

Address _____ Date signed _____

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

SUPPLEMENTARY

S-18921