

FILED JUN 28 1948

Registration District No. **318** Primary Registration District No. **1003**

1. PLACE OF DEATH:
(a) County St. Louis
(b) City or town St. Louis
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Homer G Phillips Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 9 days
In this community Life (Specify whether years, months or days)

3. (a) PRINT FULL NAME Sam Rhodes
3. (b) If veteran, name war No
3. (c) Social Security No. No
4. Sex MALE
5. Color Col
6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife Mollie
6. (c) Age of husband or wife if alive 79 years
7. Birth date of deceased 6 15 1875
(Month) (Day) (Year)

8. AGE: Years 72 Months 11 Days 26
If less than one day hr. min.

9. Birthplace ST LOUIS MO
(City, town, or county) (State or foreign country)
10. Usual occupation LABORER

11. Industry or business UNKNOWN
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 James Rhodes
(b) Address 32912 Lucas
17. (a) Burial (b) Date thereof 6-16-48
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Greenwood

18. (a) Signature of funeral director James Rhodes
(b) Address 3103 Washington
19. (a) JUN 15 1948 (b) J. F. Bradford
(Date received local registration) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County 000
(c) City or town St. Louis
(If outside city or town limits, write "RURAL") 17
(d) Street No. 2328 LaSalle
22 (If rural, give location) 9
(e) Citizen of foreign country? 0 (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month June day 11
year 1948 hour 11 minute 35 P M.
21. I hereby certify that I attended the deceased from June 2, 1948, to June 11, 1948
that I last saw him alive on June 11, 1948
and that death occurred on the date and hour stated above.

Immediate cause of death Degenerative Heart Disease with Decompensation Duration Undet.

Due to _____
Due to _____
Other conditions None
(Include pregnancy within 3 months of death)
Major findings:
Of operations _____
Of autopsy No

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?
Signature Oscar Daniels (M. D. or other) _____
Address 2601 N Whittier Date signed 6/14/48

FATHER
MOTHER

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

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 *W. Claude Jordan*
Licensed Embalmer No. *3489*
P. O. Address *4575 Alder*

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.