

No. 2
-8-43
-17-39
X37823

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED SEP 10 1948

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **26885**

Registration District No. **172** Primary Registration District No. **5641** Registrar's No. **23**

1. PLACE OF DEATH:
(a) County **Lafayette**
(b) City or town **High Prairie**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: **Confederate Home**
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **since 1934**
(Specify whether)

2. USUAL RESIDENCE OF DECEASED:
(a) State **Mo** (b) County **Lafayette**
(c) City or town **Confederate Home**
(If outside city or town limits, write "RURAL")
(d) Street No. **546**
(Specify location)
(e) Citizen of foreign country? **No** (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME **Loren Alice Madson Rhoades**
3. (b) If veteran, name war
3. (c) Social Security No. **2**

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month **August** day **19** year **1948** hour **11** minute **19** M.
21. I hereby certify that I attended the deceased from **Jan. 1948**
19 **August** 19 **48**
that I last saw h. **er** alive on **Aug. 19,** 19 **48**
and that death occurred on the date and hour stated above.

4. Sex **Female** **5. Color or race** **White** **6. (a) Single, widowed, married, divorced** **widowed**
6. (b) Name of husband or wife **alive** years
6. (c) Age of husband or wife if **2** years
7. Birth date of deceased **May 7 1864**
(Month) (Day) (Year)

Immediate cause of death: **Ruptured aortic aneurysm** Duration **Immedia**
Due to **Long-standing aortic aneurysm and chronic arteriosclerotic vascular disease** **20 yrs.**

8. AGE: Years **84** Months **3** Days **12** If less than one day hr. min.
9. Birthplace **Near Gibson Mo**
(City, town, or county) (State or foreign country)
10. Usual occupation **House Wife**

Other conditions: (Include pregnancy within 3 months of death)
Major findings: Of operations **no P**
Of autopsy **no P**
PHYSICIAN
Underline the cause to which death should be charged statistically.

MOTHER FATHER

11. Industry or business
12. Name **E. M. Cornich**
13. Birthplace **Don't know**
(City, town, or county) (State or foreign country)
14. Maiden name **Don't know**
15. Birthplace **Don't know**
(City, town, or county) (State or foreign country)
16. (a) Informant **Mrs. Nora M. Cornich**
(b) Address **State No 8-22-48**
17. (a) Burial (b) Date thereof **8-22-48**
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: Burial or cremation **State City Cemetery**
18. (a) Signature of funeral director **James J. Salzer**
(b) Address **State No**
19. (a) Aug 20-48 (b) **Clayton D. Landrum**
(Date received local registrar) (Registrar's signature) **154**

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) While at work? (e) Means of injury
23. Signature **James J. Salzer** (M. D. ~~number~~)
Address **Higginsville, Mo.** Date signed **8-20-48**

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

RECEIVED

District Health Officer No. 8,

District File Number

Date Filed 9-9-48

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

Richard V. Drummond

Registered Apprentice No. 103

working under my personal supervision.

Signed

James E. Jones

Licensed Embalmer No. 23143

P. O. Address Slater, 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.