

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

14088

FILED MAY 5 1949

State File No. ....

318

PRIMARY REG. DIST. NO. 1003

Registrar's No. .... 3617

BIRTH NO. _____		REG. DIST. NO. _____		PRIMARY REG. DIST. NO. _____		Registrar's No. ....	
1. PLACE OF DEATH a. COUNTY _____				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY _____			
b. CITY (If outside corporate limits, write RURAL and give OR TOWN <u>ST. Louis</u> )		c. LENGTH OF STAY (In this place) <u>2 Yrs</u>		c. CITY (If outside corporate limits, write RURAL and give township) <u>ST. Louis</u>			
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Homer G Phillips Hospital</u>				d. STREET ADDRESS (If rural, give location) <u>1324, North tenth Street</u>			
3. NAME OF DECEASED (Type or Print) a. (First) <u>John</u> b. (Middle) _____ c. (Last) <u>Rhodes</u>			4. DATE OF DEATH (Month) (Day) (Year) <u>April 18 1949</u>				
5. SEX <u>Male</u>		6. COLOR OR RACE <u>Col.</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Widowed</u>		8. DATE OF BIRTH <u>Aug. 26th 1887</u>	
9. AGE (In years last birthday) <u>61</u>		IF UNDER 1 YEAR Months <u>8</u> Days <u>22</u>		IF UNDER 1 HRS. Hours _____ Min. _____			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Domestic</u>		11. BIRTHPLACE (State or foreign country) <u>Rolla, North Carolina</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13a. FATHER'S NAME <u>Jim. Rhodes</u>		13b. MOTHER'S MAIDEN NAME <u>Susie. Davis</u>		14. NAME OF HUSBAND OR WIFE <u>Unknown</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT'S SIGNATURE OR NAME <u>Nora Davis</u>		ADDRESS <u>1237 No. Ninth Street</u>	
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)  *This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Degenerative Heart Disease with</u>  ANTECEDENT CAUSES <u>Generalized Arteriosclerosis</u> DUE TO (b) _____ DUE TO (c) _____  II. OTHER SIGNIFICANT CONDITIONS <u>Undetermined</u>				INTERVAL BETWEEN ONSET AND DEATH <u>Undet.</u>	
19a. DATE OF OPERATION _____		19b. MAJOR FINDINGS OF OPERATION _____				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT SUICIDE HOMICIDE (Specify) _____		21b. PLACE OF INJURY (e.g., to or about home, farm, factory, street, office bldg., etc.) _____		21c. (CITY, TOWN, OR TOWNSHIP) _____ (COUNTY) _____ (STATE) _____			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) _____		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? _____			
22. I hereby certify that I attended the deceased from <u>4-10</u> , 19 <u>49</u> , to <u>4-18</u> , 19 <u>49</u> , that I last saw the deceased alive on <u>4-18</u> , 19 <u>49</u> , and that death occurred at <u>8:35 Pm.</u> , from the causes and on the date stated above.							
23a. SIGNATURE (Degree or title) <u>Oscar L. Daniels M. D.</u>			23b. ADDRESS <u>2601 N Whittier St.</u>			23c. DATE SIGNED <u>4-19-49</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		24b. DATE <u>4-25-49</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Oak Dale Cemetery</u>		24d. LOCATION (City, town, or county) (State) <u>ST. Louis MO.</u>	
DATE REC'D BY LOCAL REGISTRAR'S SIGNATURE <u>APR 22 1949</u>		REGISTRAR'S SIGNATURE <u>J. B. Sabatino</u>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Cartwright &amp; Sedan 3951, Finney Ave.</u>			

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

STATEMENT BY LICENSED EMBALMER

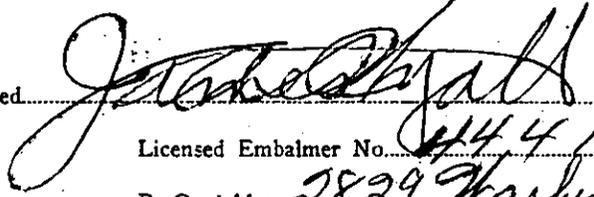
I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....

Student Embalmer No. ....

working under my personal supervision.

Student .....  
Student Embalmer

Signed.....



Licensed Embalmer No. ....

P. O. Address 2829 Washington

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.