

No. 300  
No. 48

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# STANDARD CERTIFICATE OF DEATH

State File No. 6218  
Registrar's No. 325

|   |                             |  |   |   |  |  |   |  |
|---|-----------------------------|--|---|---|--|--|---|--|
| BIRTH NO. _____   |                             | REG. DIST. NO. <u>317</u>  |   | PRIMARY REG. DIST. NO. <u>3063</u>  |  | Registrar's No. <u>325</u>   |   |  |
| 1. PLACE OF DEATH<br>a. COUNTY <u>ST LOUIS</u>  |                             |  |   | 2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).<br>a. STATE <u>MO</u><br>b. COUNTY <u>ST LOUIS</u>                     |  |  |   |  |
| b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>CLAYTON</u>   |                             | c. LENGTH OF STAY (In this place) <u>2 DAYS</u>  |   | c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>WEBSTER GROVES 4787</u>   |  | d. STREET ADDRESS (If rural, give location) <u>104 WILLIS</u>                    |   |  |
| d. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION <u>ST LOUIS CO HOSPITAL</u>  |                             |  |   |   |  |  |   |  |
| 3. NAME OF DECEASED.<br>(Type or Print) a. (First) <u>Tamila</u>  |                             |  | b. (Middle) _____                               |   | c. (Last) <u>Rhodes</u>                  |  | 4. DATE OF DEATH (Month) (Day) (Year) <u>2-7-51</u> |  |
| 5. SEX <u>F</u>   | 6. COLOR OR RACE <u>Col</u> | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>0</u>  |   | 8. DATE OF BIRTH <u>9/1/50</u>  | 9. AGE (In years last birthday) <u>3</u> |  | IF UNDER 1 YEAR Months Days                         |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)   |                             | 10b. KIND OF BUSINESS OR INDUSTRY _____  |   | 11. BIRTHPLACE (State or foreign country) <u>WEBSTER GROVES MO</u>  |  | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u>  |   |  |
| 13a. FATHER'S NAME <u>HARVEY RHODES</u>   |                             |  | 13b. MOTHER'S MAIDEN NAME <u>MALISSA RHODES</u> |   | 14. NAME OF HUSBAND OR WIFE _____        |  |   |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)   |                             | 16. SOCIAL SECURITY NO. _____  |   | 17. INFORMANT'S SIGNATURE OR NAME <u>HARVEY RHODES</u>  |  | ADDRESS <u>104 WILLIS</u>  |   |  |
| 18. CAUSE OF DEATH<br>Enter only one cause per line for (a), (b), and (c)<br><br>*This does not mean the mode of dying, such as heart failure, asphyxia, etc. It means the disease, injury, or complication which caused death.   |                             |  |   | MEDICAL CERTIFICATION<br>I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Pneumonia</u>  |  |  | INTERVAL BETWEEN ONSET AND DEATH <u>1 week</u>      |  |
|   |                             |  |   | ANTECEDENT CAUSES<br>Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.<br>DUE TO (b) _____<br>DUE TO (c) _____ |  |  |   |  |
|   |                             |  |   | II. OTHER SIGNIFICANT CONDITIONS<br>Conditions contributing to the death but not related to the disease or condition causing death.                           |  |  |   |  |
| 19a. DATE OF OPERATION _____  |                             | 19b. MAJOR FINDINGS OF OPERATION _____   |   |   |  | 20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |   |  |
| 21a. ACCIDENT SUICIDE HOMICIDE (Specify) _____  |                             | 21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) _____         |   | 21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) <u>493X</u>   |  |  |   |  |
| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min) _____   |                             | 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>2-5</u> , 19 <u>51</u> , to <u>2-7</u> , 19 <u>51</u> , that I last saw the deceased alive on <u>2-7</u> , 19 <u>51</u> , and that death occurred at <u>2:30 A.M.</u> , from the causes and on the date stated above. |                             |  |   |   |  |  |   |  |
| 23a. SIGNATURE (Degree or title) <u>H. J. Waltherman, M.D.</u>  |                             |  |   | 23b. ADDRESS <u>St. Louis Co. Hospital</u>  |  | 23c. DATE SIGNED <u>2/7/51</u>   |   |  |
| 24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>   |                             | 24b. DATE <u>2/10/51</u>   |   | 24c. NAME OF CEMETERY OR CREMATORY <u>FATHER PICKSON</u>  |  | 24d. LOCATION (City, town, or county) (State) <u>ST LOUIS CO MO</u>              |   |  |
| DATE REC'D BY LOCAL REG. <u>2/9/51</u>  |                             | REGISTRAR'S SIGNATURE <u>Arthur P. Tomke, M.D.</u>   |   | 25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Susan C. Lewis 225 E. 4th W 8</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.....

working under my personal supervision.

Student Embalmer No.....

Signed.....

*A. P. Richardson*

Signed.....

Student Embalmer

Licensed Embalmer No. *2928*

P. O. Address *2675 Glasgow*

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.