

FILED AUG 16 1954

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATHState File No. 27639
3402

BIRTH NO. _____		REG. DIST. NO. <u>149</u>		PRIMARY REG. DIST. NO. <u>1002</u>		Registrar's No. _____	
1. PLACE OF DEATH a. COUNTY <u>JACKSON</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.) a. STATE <u>MISSOURI</u> b. COUNTY <u>JACKSON</u>			
b. CITY OR TOWN <u>KANSAS CITY</u>		c. LENGTH OF STAY (In this place) <u>—</u>		c. CITY OR TOWN <u>KANSAS CITY</u>		d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>3923 ST. JOHN AVENUE</u>				STREET ADDRESS (If rural, give location) <u>3923 ST. JOHN AVENUE</u>			
3. NAME OF DECEASED (Type or Print) a. (First) <u>WALTER</u> b. (Middle) <u>N.</u> c. (Last) <u>RHOADES</u>			4. DATE OF DEATH (Month) (Day) (Year) <u>JULY-13-1954</u>				
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>WIDOWED</u>		8. DATE OF BIRTH <u>JAN-30-1877</u>	
9. AGE (In years last birthday) <u>77</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETIRED-5 YEARS</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>OPTOMETRIST</u>		11. BIRTHPLACE (City and State or Foreign Country) <u>HANNIBAL, MISSOURI</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and State or Foreign Country)		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13a. FATHER'S NAME <u>STEPHEN A. RHOADES</u>			13b. MOTHER'S MAIDEN NAME <u>AMANDA ROSS</u>			14. NAME OF HUSBAND OR WIFE <u>—</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>510-05-5129</u>		17. INFORMANT'S SIGNATURE OR NAME <u>MRS. SUSAN FRAYNE</u> ADDRESS <u>3923 ST. JOHN KANSAS CITY, MO.</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, ashenia, etc. It means the disease, injury, or complication which caused death.				MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Cause of acute tuberculum</u> INTERVAL BETWEEN ONSET AND DEATH ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. 7955			
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., in or about home, farm, factory, street, office bldg., etc.)		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.		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 _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at _____ m., from the causes and on the date stated above.							
23a. SIGNATURE <u>Geo. O. Kealhofer MD</u> (Degree or title) <u>3</u>				23b. ADDRESS <u>4050 Birchley Dr. Overland Park, Mo.</u>		23c. DATE SIGNED <u>7-13-54</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		24b. DATE <u>JULY 16, 1954</u>		24c. NAME OF CEMETERY OR CREMATORY <u>MT. WASHINGTON CEM.</u>		24d. LOCATION (City, town, or county) (State) <u>KANSAS CITY MISSOURI</u>	
DATE REC'D BY LOCAL REG. <u>7-16-54</u>		REGISTRAR'S SIGNATURE <u>Geraldine Smith</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>O. H. Newcomer's Sons</u> ADDRESS <u>1331 BRUSH CREEK KANSAS CITY, MO.</u>			

(Licensed Embalmer's Statement on Reverse Side)

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.....
Signature of Student Embalmer

Signed.....

Robert C. Herron

Licensed Embalmer No..... 48

P. O. Address..... J. C. V.

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.