

FILED MAY 10 1955

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **11334**

BIRTH NO. _____ REG. DIST. NO. 91 PRIMARY REG. DIST. NO. 3012 Registrar's No. 44

1. PLACE OF DEATH a. COUNTY <u>CLAY</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>MISSOURI</u> b. COUNTY <u>CLAY</u>	
b. CITY (If outside corporate limits, write RURAL and give township) <u>EXCELSIOR SPRINGS</u>	c. LENGTH OF STAY (in this place) <u>12 yrs</u>	c. CITY OR TOWN <u>EXCELSIOR SPRINGS</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>202 SARATOGA</u>		f. STREET ADDRESS (If rural, give location) <u>202 SARATOGA</u>	

3. NAME OF DECEASED (Type or Print)	a. (First) <u>MARY</u>	b. (Middle) <u>MALZENA</u>	c. (Last) <u>RHODUS</u>	4. DATE OF DEATH (Month) (Day) (Year) <u>MAY 2 1955</u>
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5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>WIDOWED</u>	8. DATE OF BIRTH <u>NOV 25 1870</u>	9. AGE (In years last birthday) <u>84</u>	if UNDER 1 YEAR Months Days	if UNDER 2 HRS. Hours Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>NONE</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>NONE</u>	11. BIRTHPLACE (City and State or Foreign Country) <u>KEARNEY, Mo.</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
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13a. FATHER'S NAME <u>WILLIAM HAWKINS</u>	13b. MOTHER'S MAIDEN NAME	14. NAME OF HUSBAND OR WIFE <u>JOHN D. RHODUS</u>
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO</u>	16. SOCIAL SECURITY NO. <u>NONE</u>	17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>BASCOM RHODUS 202 SARATOGA EX. SPRINGS, Mo.</u>
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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		INTERVAL BETWEEN ONSET AND DEATH <u>30 hrs.</u>
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Myocardial failure</u>	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Arterio sclerotic heart disease</u>	<u>unknown</u>
	II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>acute cholecystitis with cholelithiasis</u>	DUE TO (c) <u>Generalized Arteriosclerosis</u>	<u>unknown</u>

19a. DATE OF OPERATION <u>4 MAR 55</u>	19b. MAJOR FINDINGS OF OPERATION <u>Solitary Stone - Remnants of Gall Bladder</u>	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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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>585 X</u>
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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?
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22. I hereby certify that I attended the deceased from Mar 1955, to 2 May, 1955, that I last saw the deceased alive on 2 May, 1955, and that death occurred at 8:15 p.m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) <u>Ralph P. Michelson, M.D.</u>	23b. ADDRESS <u>116 South 5th Excelsior Springs, Mo.</u>	23c. DATE SIGNED <u>3 May 1955</u>
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24a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	24b. DATE <u>5-4-55</u>	24c. NAME OF CEMETERY OR CREMATORY <u>SHADY GROVE</u>	24d. LOCATION (City, town, or county) (State) <u>RURAL KEARNEY, Mo.</u>
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DATE REC'D BY LOCAL REG. <u>5-6-55</u>	REGISTRAR'S SIGNATURE <u>Barbara Hutchings</u>	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Claude Pritchard Excelsior Springs, Mo.</u>
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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 *Lindell Gasman*

Licensed Embalmer No. *4589*
Excelsior Springs
P. O. Address

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.