

RECEIVED MAR 5 1956

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **7114**

Registrar's No. **01754**

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003**

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <b>Missouri</b> b. COUNTY <b>Wayne</b>	
b. CITY (If outside corporate limits, write RURAL and give town) <b>St. Louis</b>		c. LENGTH OF STAY (in this place)	c. CITY OR TOWN <b>Piedmont</b>
d. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION <b>Missouri Baptist Hospital</b>		d. In Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input type="checkbox"/>	
e. STREET ADDRESS (If rural, give location)		<b>1110 / 1</b>	

3. NAME OF DECEASED (Type or Print) a. (First) <b>Joseph</b> b. (Middle) c. (Last) <b>Rhodes</b>	4. DATE OF DEATH (Month) (Day) (Year) <b>Feb. 17, 1956</b>
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5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>Widow</b>	8. DATE OF BIRTH <b>Oct. 16, 1874</b>	9. AGE (In years last birthday) <b>81</b>	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Hours Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Farmer</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>Farming</b>	11. BIRTHPLACE (City and State or Foreign Country) <b>Wayne Co., Mo.</b>	12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>
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13a. FATHER'S NAME <b>Joseph Rhodes</b>	13b. MOTHER'S MAIDEN NAME <b>Elizabeth Michaels</b>	14. NAME OF HUSBAND OR WIFE <b>Ida Rhodes</b>
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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) <b>No</b>	16. SOCIAL SECURITY NO. <b>None</b>	17. INFORMANT'S SIGNATURE OR NAME ADDRESS <b>Gene Rhodes, 9919 Baltimore</b>
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))	MEDICAL CERTIFICATION <b>Overland, Mo.</b>		INTERVAL BETWEEN ONSET AND DEATH <b>3 days</b>
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Cerebral hemorrhage</b>	ANTECEDENT CAUSES <b>Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.</b>		<b>1 yr 1</b>
DUE TO (b) <b>Arterio-sclerosis</b>			
DUE TO (c)			
II. OTHER SIGNIFICANT CONDITIONS <b>Conditions contributing to the death but not related to the disease or condition causing death.</b>			

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	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)
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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?
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22. I hereby certify that I attended the deceased from **2-9, 1956, to 2-17, 1956**, that I last saw the deceased alive on **2-17, 1956**, and that death occurred at **4:00 a.m.**, from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) <b>J. A. Smith</b>	23b. ADDRESS <b>8924 St. Charles St. Louis 17, Mo.</b>	DATE SIGNED <b>2/17/56</b>
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24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>	24b. DATE <b>2-17-56</b>	24c. NAME OF CEMETERY OR CREMATORY <b>Masonic Cemetery</b>	24d. LOCATION (City, town, or county) (State) <b>Piedmont, Mo.</b>
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DATE REC'D BY LOCAL REG. <b>FEB 18 1956</b>	REGISTRAR'S SIGNATURE <b>J. Earl Smith Md</b>	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <b>Albert H. Hoppe, 4700 Washington Blvd.</b>
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WRITE PLAINLY—USING UNFADEING 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 M. Murray*.....

Licensed Embalmer No. *13*.....

P. O. Address *St. Louis*.....

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.