

Health, Welfare, Public Service

100-56

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be recorded if diseases in Part I must be causally related. Coroner cannot certify to a death due to natural causes.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

FILED MAR 12 1957

STANDARD CERTIFICATE OF DEATH

STATE FILE NUMBER 4190

Registration District No. 100 Primary Registration District No. 3018 Registrar's No. 24

1. PLACE OF DEATH a. COUNTY Dent		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Dent	
b. CITY (If outside corporate limits, give TOWNSHIP only) Inside Limits OR TOWN Salem Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN Salem 0331 Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Hart Clinic Length of stay in lb		d. STREET ADDRESS W. Olive Ave (give location) Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First William Middle F Last Rhodes			4. DATE OF DEATH Month Mar Day 27 Year 1957		
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5. SEX male	6. COLOR OR RACE white 0	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> / DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug 24 1872 84	9. AGE (In years last birthday)	IF UNDER 1 YEAR Month	IF UNDER 24 HRS. Days Hours Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) merchant	10b. KIND OF BUSINESS OR INDUSTRY Grocery	11. BIRTHPLACE (City and state or country) Randolph Co Ark /	12. CITIZEN OF WHAT COUNTRY? U S
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13. FATHER'S NAME John Rhodes	14. MOTHER'S MAIDEN NAME Catherine Lewis
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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) No X	16. SOCIAL SECURITY NO. X	17. INFORMANT Address Mrs Ida Rhodes Salem Mo W. Cave
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18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Stroke idiopathic aneurysm</u>		INTERVAL BETWEEN ONSET AND DEATH 3 mos.
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b)	
	DUE TO (c)	

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Subacute yellow atrophy of liver - diabetes mellitus 260X</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
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20c. TIME OF INJURY Hour a. m. p. m.	20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION COUNTY STATE
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21. I attended the deceased from 2-19-57 to 2-27-57 and last saw her alive on 2-26-57 Death occurred at 5-25 P m on the date stated above; and to the best of my knowledge, from the causes stated.
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22a. SIGNATURE <u>J. W. McJunk</u> (Degree or title) 2	22b. ADDRESS <u>Salem Mo.</u>	22c. DATE SIGNED 3-1-57
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23a. BURIAL CREMATION REMOVAL (Specify) <u>burial</u>	23b. DATE Mar 2 - 57	23c. NAME OF CEMETERY OR CREMATORY Jadwin Cem	23d. LOCATION (City, town, or county) (State) Jadwin Dent Co Mo
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24. FUNERAL DIRECTOR <u>Carl D. Spitzer</u> ADDRESS <u>Salem Mo.</u>	25. DATE RECD. BY LOCAL REG. 3/2/57	26. REGISTRAR'S SIGNATURE <u>M. M. Hart MD Ryph</u>
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(Licensed Embalmer's Statement on Reverse Side)

**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.....  
*Carl H. Johnson*

Licensed Embalmer No. *23*

P. O. Address *Salem*

**Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (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.