

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

4949

STATE FILE NUMBER

FILED MAR 4 1957

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 638

1. PLACE OF DEATH a. COUNTY <i>Jackson</i>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>mo</i> b. COUNT <i>Jackson</i>												
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <i>Kansas City</i>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN <i>Kansas City</i>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>										
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <i>St. Joseph Hosp</i>			Length of stay in lb <i>67 yrs</i>		d. STREET ADDRESS <i>6015 E. 15th Ave</i>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>									
3. NAME OF DECEASED (Type or print) First <i>OLLIE</i> Middle <i>E</i> Last <i>RHOADES</i>				4. DATE OF DEATH Month <i>2</i> Day <i>8</i> Year <i>1957</i>												
5. SEX <i>male</i>		6. COLOR OR RACE <i>white</i>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>12-8-1887</i>		9. AGE (In years last birthday) <i>69</i>		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Mechanic</i>				10b. KIND OF BUSINESS OR INDUSTRY —		11. BIRTHPLACE (City and state or country) <i>Kansas</i>				12. CITIZEN OF WHAT COUNTRY? <i>USA</i>						
13. FATHER'S NAME <i>John T. Rhoades</i>						14. MOTHER'S MAIDEN NAME <i>Sarah Pierce</i>										
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <i>no</i>				16. SOCIAL SECURITY NO. <i>486-05-2704</i>		17. INFORMANT <i>Mrs Sade Rhoades</i>				Address <i>tc mo.</i>						
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Carcinoma Left Kidney</i>										INTERVAL BETWEEN ONSET AND DEATH <i>180x</i>						
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)										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>						
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.) <i>0</i>													
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					
21. I attended the deceased from <i>4-4-57</i> to <i>2-8-57</i> and last saw her alive on <i>2-8-57</i> Death occurred at <i>4 AM</i> m on the date stated above; and to the best of my knowledge, from the causes stated.																
22a. SIGNATURE <i>Thomas E. Minshall MD</i> (Degree or title)						22b. ADDRESS <i>1019 Buena Vista Blvd. N.C. Mo.</i>				22c. DATE SIGNED <i>2-8-57</i>						
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE <i>2-11-57</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Forest Hill Cem</i>				23d. LOCATION (City, town, or county) (State) <i>Kansas City, Mo</i>							
24. FUNERAL DIRECTOR <i>Pasantino Bros, N.C. Mo</i>					ADDRESS				25. DATE RECD. BY LOCAL REG. <i>2-9-57</i>				26. REGISTRAR'S SIGNATURE <i>reva minshall</i>			

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE
Thomas E. Minshall
MEDICAL CERTIFICATION

Dr. McMillan
Professional Body
Ha 14022

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 *Leonard Pasquino*.....

Licensed Embalmer No. *45*

P. O. Address *KC Mo*

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.