

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-025396

FILED VS AUG 14 1959

Registration District No. 49 Primary Registration District No. 1002 Registrar's No. 3717 STATE FILE NUMBER

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 (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Kansas City, Mo.</u>		Length of stay in 1b <u>2 mo.</u>	c. CITY OR TOWN <u>Osce</u>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Childrens Mercy Hospital</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>-</u>
		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First <u>Rhonda</u> Middle <u>Sue</u> Last <u>Rodgers</u>			4. DATE OF DEATH Month <u>7</u> Day <u>31</u> Year <u>1959</u>			
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5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>9-11-58</u>	9. AGE (last birthday) <u>10 mo.</u>	IF UNDER 1 YEAR Months <u>10</u> Days <u>-</u> Hours <u>-</u> Min. <u>-</u>	IF UNDER 24 HR Hours <u>-</u> Min. <u>-</u>
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>-</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>-</u>	11. BIRTHPLACE (City and state or country) <u>Gainsville, Mo.</u>	12. CITIZEN OF WHAT COUNTRY <u>USA.</u>
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13a. FATHER'S NAME <u>Tommy Rodgers</u>	13b. MOTHER'S MAIDEN NAME <u>Lou Ann Richardson</u>	14. NAME OF HUSBAND OR WIFE <u>-</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>-</u>	16. SOCIAL SECURITY NO. <u>-</u>	17. INFORMANT <u>Lou Ann Rodgers</u>	Address <u>Osce, Mo.</u>
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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>Cachexia and malnutrition</u>		INTERVAL BETWEEN ONSET AND DEATH <u>5 mo.</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <u>membranous enteritis, cause unknown</u>	
	DUE TO (c) <u>-</u>	

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>-</u>	PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown
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19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" 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.) <u>-</u>
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20c. TIME OF INJURY Hour <u>-</u> a.m. <u>-</u> p.m. <u>-</u>	Month, Day, Year <u>-</u>
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20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>-</u>	20f. CITY, TOWN, OR LOCATION <u>-</u>	COUNTY <u>-</u>	STATE <u>-</u>
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21. I attended the deceased from <u>6-1-59</u> to <u>7-31-59</u> and last saw her <u>her</u> alive on <u>7-31-59</u>	
Death occurred at <u>9:52</u> <u>A.</u> m on the date stated above, and to the best of my knowledge, from the causes stated.	

22a. SIGNATURE (Degree or title) <u>R.D. Parnon M.D.</u>	22b. ADDRESS <u>1710 Independence Ave.</u>	22c. DATE SIGNED <u>7/31/59</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	23b. DATE <u>8-1-59</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Berk Shed Cem</u>	23d. LOCATION (City, town, or county) (State) <u>Springdale Mo</u>
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24. FUNERAL DIRECTOR <u>Sheel Funeral Home N.E. Mo.</u>	ADDRESS <u>-</u>	25. DATE RECD. BY LOCAL REG. <u>8-1-59</u>	26. REGISTRAR'S SIGNATURE <u>neva Marshall</u>
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DOCUMENT
MEDICAL CERTIFICATION
BY AFFIDAVIT OF R. D. Parnon

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed Richard E. Carroll

Licensed Embalmer No. 4929

P. O. Address H.C. Moore

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