

# JURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-034951

FILED VS OCT 7 1959

356

Registration District No. 4521 Registrar's No. 79

STATE FILE NUMBER

ENDED

1. PLACE OF DEATH a. COUNTY <b>TEXAS</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MO.</b> b. COUNTY <b>WRIGHT</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>HOUSTON</b>		c. CITY OR TOWN <b>MTN. GROVE</b>	
Length of stay in lb <b>5 days</b>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>TEXAS COUNTY HOSP.</b>		d. STREET ADDRESS (If outside, give location) <b>RURAL</b>	
Yes <input checked="" type="checkbox"/> No <input checked="" type="checkbox"/>		Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First Middle Last <b>GEORGE W. RHODES</b>			4. DATE OF DEATH Month Day Year <b>SEPT. 27 - 59</b>			
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>FEB. 18 1882</b>	9. AGE (last birthday) <b>76</b>	IF UNDER 1 YEAR IF UNDER 24 HR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>FARMER</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>SAME</b>		11. BIRTHPLACE (City and state or country) <b>MO.</b>		12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>
13a. FATHER'S NAME <b>CALUP RHODES</b>		13b. MOTHER'S MAIDEN NAME <b>EASTER ANN PETERSON</b>		14. NAME OF HUSBAND OR WIFE <b>SUSIE OWENS</b>		
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>L</b>		17. INFORMANT Address <b>JAMES RHODES MTN. GROVE</b>		

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:			INTERVAL BETWEEN ONSET AND DEATH <b>96 hours</b> <b>2 years</b> <b>5 years</b>
IMMEDIATE CAUSE (a) <b>Cerebral Embolism</b>			
DUE TO (b) <b>Cerebral Thrombosis</b>			
DUE TO (c) <b>Arteriosclerosis</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)			PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown

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.)	
20c. TIME OF INJURY Hour a.m. p.m.	Month, Day, Year		
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 **Sept 23, 59** to **Sept 27, 59** and last saw him alive on **Sept 27, 1959**  
Death occurred at **4:30 am** on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) <b>Richard S. Mitchell D.O.</b>		22b. ADDRESS <b>Mtn Grove, MO</b>		22c. DATE SIGNED <b>9-28-59</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	23b. DATE <b>SEPT-29-59</b>	23c. NAME OF CEMETERY OR CREMATORY <b>LOVE STAR</b>	23d. LOCATION (City, town, or county) (State) <b>MTN. GROVE MO.</b>	
24. FUNERAL DIRECTOR <b>BARBER F. HOMIE</b>	ADDRESS <b>MTN. GROVE</b>		25. DATE RECD. BY LOCAL REG. <b>Sept 30, 59</b>	26. REGISTRAR'S SIGNATURE <b>Myrtle Craig</b>

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

**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 RW Barber

Licensed Embalmer No. 984

P. O. Address Wm. H. H.

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.