

DEPARTMENT OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS SEP 20 1960

-60-034986

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 4557 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) <u>Kansas City</u>		Length of stay in 1b <u>10 yrs.</u>		c. CITY OR TOWN <u>Kansas City</u>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Kings Rest Home</u>				Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <u>926 Brooklyn st.</u>	
3. NAME OF DECEASED (Type or print) First <u>Aline</u> Middle <u>G.</u> Last <u>Rhodes</u>				4. DATE OF DEATH Month <u>9</u> Day <u>1</u> Year <u>1960</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Negro</u>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>2/22/1901</u>	9. AGE (last birthday) <u>59</u>	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HR Hours _____ Min. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House work</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Lester Dean</u> <u>1207 W. 66 th. st.</u>		11. BIRTHPLACE (City and state or country). <u>Edwardsville, Kansas</u>		12. CITIZEN OF WHAT COUNTRY <u>U. S. A.</u>	
13a. FATHER'S NAME <u>Harry Divers</u>		13b. MOTHER'S MAIDEN NAME <u>Ida Jordan</u>		14. NAME OF HUSBAND OR WIFE <u>Gaston Rhodes</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>515-14-7749</u>		17. INFORMANT Address <u>Brethard R. Divers 2030 N.5th. st. Kans.</u>			
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>Sub Arachnoid Hemorrhage</u> DUE TO (b) <u>Ruptured Aneurysm</u> DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.						INTERVAL BETWEEN ONSET AND DEATH	
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 checked="" type="checkbox"/> No <input type="checkbox"/> Unknown	
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.)			
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 <u>April 9, 1960</u> to <u>September 1, 60</u> and last saw her alive on <u>June 4, 1960</u> Death occurred at _____ <u>8: A.m</u> on the date stated above, and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE <u>James P. Mc Donald M.D.</u> (Degree or title)				22b. ADDRESS <u>2604 Prospect Avenue</u>		22c. DATE SIGNED <u>9/3/60</u>	
23a. MANNER OF REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>9/6/1960</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Westlawn Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Kansas City, Kansas</u>		
24. FUNERAL DIRECTOR <u>Mrs. J. W. Jones 440 state ave.</u>			25. DATE RECD. BY LOCAL REG. <u>9-6-60</u>		26. REGISTRAR'S SIGNATURE <u>H. E. Dwyer</u>		

DOCUMENT

BY AFFIDAVIT OF James P. Mc Donald MEDICAL CERTIFICATION

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 Engene English

Licensed Embalmer No. 4109

P. O. Address 4400 S. La
Rm

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.