

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-031573

STATE FILE NUMBER

Registration District No. 333 Primary Registration District No. 3074 Registrar's No. 176

AMENDED

FILED SEP 11 1961

1. PLACE OF DEATH a. COUNTY <u>Scott County</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>Stoddard</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Sikeston</u>		Length of stay in 1b <u>6 mos</u>	c. CITY OR TOWN <u>ADVANCE</u> Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Shuffit Nursing Home</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>R#2, Fike Twp.</u> Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>

3. NAME OF DECEASED (Type or print) First Middle Last <u>CORA BETHANY RHODES</u>			4. DATE OF DEATH Month Day Year <u>Aug. 26, 1961</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</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>12-31-78</u>	9. AGE (last birthday) <u>82</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>HOUSEHOLD</u>	11. BIRTHPLACE (City and state or country) <u>CAPE GIRARDEAU B. MO. U. S. A.</u>	
12. CITIZEN OF WHAT COUNTRY <u>U. S. A.</u>		13a. FATHER'S NAME <u>John English</u>		13b. MOTHER'S MAIDEN NAME <u>UNKNOWN</u>
14. NAME OF HUSBAND OR WIFE <u>JAMES W. 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>NONE</u>		17. INFORMANT Address <u>Mrs. James Warren, Detroit, Mich</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>Cerebrovascular accident</u>		INTERVAL BETWEEN ONSET AND DEATH <u>7 days</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Cerebrovascular</u>		
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>Probable aortic aneurysm - abd.</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
---	--	---

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 Month, Day, Year 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 <u>Sikeston</u>	COUNTY <u>Scott</u>	STATE <u>Mo.</u>
--	--	---	------------------------	---------------------

21. I attended the deceased from 3/23/61 to 8/26/61 and last saw her him alive on 8/25/61
Death occurred at 1:30 A.M. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <u>E. D. Urban, M.D.</u>	(Degree or title)	22b. ADDRESS <u>Sikeston</u>	22c. DATE SIGNED <u>9/5/61</u>
--	-------------------	---------------------------------	-----------------------------------

23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE <u>9-27-61</u>	23c. NAME OF CEMETERY OR CREMATORY <u>MORGAN MEMORIAL PARK</u>	23d. LOCATION (City, town, or county) (State) <u>ADVANCE Mo.</u>
--	-----------------------------	---	---

24. FUNERAL DIRECTOR <u>W. H. Morgan</u>	ADDRESS <u>Advance, Mo.</u>	25. DATE RECD. BY LOCAL REG. <u>9-6-61</u>	26. REGISTRAR'S SIGNATURE <u>Max Eller Hunter</u>
---	--------------------------------	---	--

DATE AMENDED
INSTEAD OF
DOCUMENT
MEDICAL CERTIFICATION
SHOULD READ
BY AFFIDAVIT OF
ITEM NO.

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

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 W^m H. Morgan

Licensed Embalmer No. 4640

P. O. Address Advance, Va.

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.