

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-62-004939

STATE FILE NUMBER

Registration District No. 317 Primary Registration District No. 590 Registrar's No. 170

FILED JAN 19 1962

AMENDED

| | | | |
|---|--|---|--|
| 1. PLACE OF DEATH a. COUNTY St. Louis | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo. b. COUNTY St. Louis | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Valley Park | | c. CITY OR TOWN Webster Groves | |
| Length of stay in 1b MONS. | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Cedarcroft Nursing Home. | | d. STREET ADDRESS (If outside, give location) 9 Elm Place | |
| Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> | | Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> | |

| | | | | | | |
|--|----------------------------|--|--|--|--|---|
| 3. NAME OF DECEASED (Type or print) First Elizabeth Middle Rhodes Last McKinley | | | 4. DATE OF DEATH Month Jan. Day 12 Year 1962 | | | |
| 5. SEX F. | 6. COLOR OR RACE W. | 7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/> | 8. DATE OF BIRTH 5/8/76 | 9. AGE (last birthday) 85 | 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) Housewife | | 10b. KIND OF BUSINESS OR INDUSTRY none | | 11. BIRTHPLACE (City and state or country) Keokuk, Iowa | | 12. CITIZEN OF WHAT COUNTRY U. S. A. |
| 13a. FATHER'S NAME Wm. Horace Rhodes | | 13b. MOTHER'S MAIDEN NAME Mary Austin | | 14. NAME OF HUSBAND OR WIFE Samuel John McKinley Jr | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no | | 16. SOCIAL SECURITY NO. none | | 17. INFORMANT Address W. R. Rhodes, 9 Elm Pl. Web. G. | | |

| | | |
|--|--|----------------------------------|
| 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 |
| IMMEDIATE CAUSE (a) Coronary Occlusion | | 1 day |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. | DUE TO (b) Generalized arteriosclerosis | 2 yrs |
| | DUE TO (c) | |

| | |
|--|---|
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Bronchopneumonia | 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 6-12-62 to 1-12-62 and last saw her her alive on 1-11-62
Death occurred at 7:30 PM. m on the date stated above, and to the best of my knowledge, from the causes stated.

| | | | |
|-----------------------------------|-----------------|-------------------------------------|---------------------------------|
| 22a. SIGNATURE [Signature] | Degree or title | 22b. ADDRESS Likwood 22, Mo. | 22c. DATE SIGNED 1/13/62 |
|-----------------------------------|-----------------|-------------------------------------|---------------------------------|

| | | | |
|--|--------------------------|--|--|
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Cremation | 23b. DATE 1/13/62 | 23c. NAME OF CEMETERY OR CREMATORY Valhalla Crematory | 23d. LOCATION (City, town, or county) (State) St. Louis County, Mo. |
|--|--------------------------|--|--|

| | | | |
|---|---------|---|--|
| 24. FUNERAL DIRECTOR Parker-Aldrich, Webster Groves, Mo. | ADDRESS | 25. DATE RECD. BY LOCAL REG. 1-13-62 | 26. REGISTRAR'S SIGNATURE [Signature] |
|---|---------|---|--|

DATE AMENDED
 AMENDMENTS ON THIS RECORD ARE AS FOLLOWS
 INSTEAD OF
 DOCUMENT
 MEDICAL CERTIFICATION
 BY AFFIDAVIT OF
 ITEM NO. SHOULD READ

STATE OF TEXAS

also ...
...
...

...
...
...
...
...
...
...
...

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 Leslie Welch

Licensed Embalmer No. 4395

P. O. Address Walter Groves

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.