

# MISSOURI DIVISION OF HEALTH—STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

Registration District No. **318** Primary Registration District No. **1003** Registrar's No. **13108** STATE FILE NUMBER **0051048**

DO NOT WRITE ON THIS STUB  
AMENDED

VS 300  
Rev. 4/59

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2 **220**

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

ITEM NO. SHOULD READ

1. PLACE OF DEATH a. COUNTY <b>D 23 64</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MISSOURI</b> b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>ST. LOUIS</b>		Length of stay in 1b' <b>50 Yrs</b>	
c. CITY OR TOWN <b>ST. LOUIS</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>2817, MADISON</b>		d. STREET ADDRESS (If outside, give location) <b>2817, MADISON</b>	
Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>James Wesley Rhodes</b> First <b>JAMES</b> Middle <b>WESLEY</b> Last <b>RHODES</b>			4. DATE OF DEATH Month <b>12</b> Day <b>28</b> Year <b>1963</b>
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>COL.</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>9-1-1880</b>
9. AGE (last birthday) <b>83</b>		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) <b>LABORER</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>KREY PACKING CO.</b>	11. BIRTHPLACE (City and state or country) <b>MERIDIAN MISSISSIPPI</b>
12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>		13a. FATHER'S NAME <b>GEN W. RHODES</b>	
13b. MOTHER'S MAIDEN NAME <b>FANNY McDONALD</b>		14. NAME OF HUSBAND OR WIFE <b>SARAH RHODES</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <b>NO NONE</b>		16. SOCIAL SECURITY NO. <b>RUBEN RHODES 2589, A MONTGOMERY (Rear)</b>	
17. INFORMANT <b>RUBEN RHODES 2589, A MONTGOMERY (Rear)</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Hemorrhage</b>			INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) DUE TO (c) <b>331x</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 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.		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 _____ to _____ and last saw her/him alive on _____ Death occurred at <b>5:05 p.</b> m on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Doctor or title) <b>Paul Simon Deputy Coroner</b>		22b. ADDRESS <b>1300 Clark</b>	
22c. DATE SIGNED <b>12/31/63</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>REMOVAL</b>		23b. DATE <b>I-3-1964</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>FATHER DICKSON CEMETERY</b>		23d. LOCATION (City, town, or county) (State) <b>ST. LOUIS MISSOURI</b>	
24. FUNERAL DIRECTOR <b>John Houston</b>		25. DATE RECD. BY LOCAL REG. <b>JAN 3 1964</b>	
26. ADDRESS <b>2812, THOMAS.</b>		26. REGISTRAR'S SIGNATURE <b>Paul Smith, M.D.</b>	

USE BLACK INK OR TYPEWRITER RIBBON

3401200

NO 53031742

**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 Thelma E. Cooper

Licensed Embalmer No. 4600

P. O. Address 4144 St. Ferdinand

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.