MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

Do not use this space. 11823

1. PLACE OF DEATH
County Jackson — Registration District No. 399
Township Kaw — Primary Registration District No. 1002
City Kansas City (No. 3908 E. 14 St. ..... Ward)
File No. ..... Registered No. 1619

2. FULL NAME Anna Rhodes
(a) Residence. No. 3908 E. 14th St., ... Ward. ..... (If nonresident give city or town and State)
(Usual place of abode)
Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U.S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: Colored
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word): Widow

5A. IF MARRIED, WIDOWED, OR DIVORCED ~~HUSBAND OF~~ (OR) WIFE OF Edward Rhodes

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Nov. 26-1856

7. AGE: 71 YEARS, 5 MONTHS, 11 DAYS. If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work House wife 96 11 SA
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer .....

9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) MO.

PARENTS
10. NAME OF FATHER John Eckles
11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) M.O.
12. MAIDEN NAME OF MOTHER Harriett Moss
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) Tenn.

14. INFORMANT Anna Rhodes
(Address) 3908 E. 14 St

15. FILED 4/18, 1927 M. M. Crowe Asst. REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) April 15 1927

17. I HEREBY CERTIFY, That I attended deceased from Jany 27, 1927, to Apr 15, 1927, that I last saw her alive on Apr 14, 1927, and that death occurred, on the date stated above, at 5:10 p.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Aneurism of Arch aorta
N.A. (duration) ..... yrs. ..... mos. ..... ds.
CONTRIBUTORY (SECONDARY) Focal infection - Teeth & Tonsils
(duration) ..... yrs. ..... mos. ..... ds.

18. WHERE WAS DISEASE CONTRACTED IF NOT AT PLACE OF DEATH? Dont Know
DID AN OPERATION PRECEDE DEATH? no DATE OF —
WAS THERE AN AUTOPSY? no
WHAT TESTS CONFIRMED DIAGNOSIS? X-ray & clinical manifestations
(Signed) J. E. Kerr, M.D.
4/16, 1927 (Address) 1716 E. 12th St.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL: Clinton, MO.
DATE OF BURIAL: 4/19 1927
20. UNDERTAKER: West, Appleton & Jones
ADDRESS: 1600 E. 19th St.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. AGE should be stated EXACTLY. PHYSICIANS should state

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ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

1. PLACE OF DEATH

County ..... Registration District No. 399 File No. 11823

Township ..... Primary Registration District No. ..... Registered No. 1619

City Kans. City No. ..... St. ..... Ward)

2. FULL NAME Anna Rhodes

(a) Residence. No. ..... St., ... Ward. .....
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F.
4. COLOR OR RACE: B.
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word): Wd

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Nov 26 - 1855 1855

7. AGE: 71 YEARS | MONTHS: 4 | DAYS: 19 | If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work .....
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) .....
(STATE OR COUNTRY)

PARENTS
10. NAME OF FATHER
11. BIRTHPLACE OF FATHER (CITY OR TOWN) .....
(STATE OR COUNTRY)
12. MAIDEN NAME OF MOTHER
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) .....
(STATE OR COUNTRY)

14. INFORMANT .....
(Address)

15. FILED 4/18, 1927 M. M. Crowe Asst REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Apr 15 1927

17. I HEREBY CERTIFY, That I attended deceased from ....., 19....., to ....., 19....., that I last saw h..... alive on ....., 19....., and that death occurred, on the date stated above, at ..... m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

.....

.....

.....

..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (SECONDARY) .....

..... (duration) ..... yrs. ..... mos. ..... ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH? .....

DID AN OPERATION PRECEDE DEATH? ..... DATE OF .....

WAS THERE AN AUTOPSY? .....

WHAT TEST CONFIRMED DIAGNOSIS? .....

(Signed) ....., M. D

, 19 (Address)

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL | DATE OF BURIAL 19

20. UNDERTAKER | ADDRESS

SUPPLEMENTARY

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW

...OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION ... important.

S-11823